"People helping people help themselves"

Division of Mental Health and Addiction

State Mental Health and Addiction Plan 2012 - 2013

8/31/2011

Table of Contents

INDIANA STATE PLAN FOR 2012 - 2013

Indiana is pleased to present a combined mental health and addiction block grant application for 2012 – 2013. The announcement by SAMHSA regarding the block grant application and the invitation to submit a combined application was met with excitement and increased interest in new opportunities for integration by the Indiana Division of Mental Health and Addiction (DMHA). Staff recognized that this block grant has greater potential to become a more meaningful and viable planning document than previous applications afforded.

In response, the Director of DMHA formed a committee of twenty-two staff to begin addressing the block grant in a spirit and effort not before attempted. Staff participants in the planning effort included all DMHA leadership, mid-managers, and policy/planning positions. This new internal planning effort brought together a far richer and broader scope than had previously been utilized in developing these applications. We feel this process has greatly increased the quality of the information included in this application.

While this process has improved the application, it has also had another interesting and pleasing benefit. Staff commented that this process has greatly increased their understanding of the function of each component of the Division as well as the block grant within DMHA. It has been decided this committee will continue to meet to discuss future planning efforts and to share the progress of the plans in this application. This committee will be closely linked to the planning and oversight activities of the DMHA planning and advisory council as well.

This document begins with an overview of the state system, which includes information about the three major population groups – youth with serious emotional disturbance (SED), adults with serious mental illness (SMI), and persons with chronic addictions (CA). The overview is organized around the five criteria that are statutorily required for the mental health block grant applications. Statutory requirements for the substance abuse prevention and treatment block grant applications are woven within the five criteria and the section following the overview, which contains an assessment of the strengths and needs of the Indiana service system. The section that follows describes the unmet service needs and critical gaps within the current system which have been identified through the planning process.

Additional sections contain the information requested in the SAMHSA instructions for the 2012 -2013 block grant application, section 3, c through p.

Overview of the State

Criterion 1 – Established System of Care

Indiana has a statewide mental health and addiction recovery system that ensures treatment availability in all 92 counties through contracts with 26 Managed Care Providers (MCPs) and other specialty providers. In ninety counties there is at least one satellite office of a Community Mental Health Center (CMHC). There is active outreach coupled with the provision of transportation to the nearest CMHC facility for services in the two counties without a satellite

office. By practice our measure of accessibility is that outpatient services are available in the county, an adjacent county or within a 60 minute drive. The State of Indiana funds administered by the Division of Mental Health and Addiction (DMHA) are utilized for individuals with a serious mental illness and/or a substance use disorder, and that are at or below 200% of poverty. This ensures that the limited funds are utilized by those most in need and least able to access mental health or addiction treatment services.

The MCPs and CMHCs are required by Indiana Administrative Code and by contract to provide a defined Continuum of Care. Continuum of care means a range of services, the provision of which is assured by a community mental health center or a managed care provider. The term includes the following:

- Individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed under this section
- Twenty-four (24) hour a day crisis intervention
- Case management to fulfill individual patient needs, including assertive case management when indicated
- Outpatient services, including intensive outpatient services, substance abuse services, and treatment
- Acute stabilization services including detoxification services
- Residential services
- Day treatment, partial hospitalization, or psychosocial rehabilitation
- Family support
- Medication evaluation and monitoring
- Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty

As a result of a recent state statutory change, a major initiative for DMHA over the next two years is redefining the continuum of care. Beginning in May 2011, DMHA convened a stakeholder workgroup to review the service system as it is currently configured. This workgroup will assist the state mental health and addiction system to fully develop a recovery-oriented system of care for all populations.

Description and definition of case management system

Case Management consists of services that help consumers gain access to needed medical, social, educational, and other services. This includes direct assistance in gaining access to services, coordination of care, oversight of the entire case, and linkage to appropriate services. Case Management does not include direct delivery of medical, clinical, or other direct services. Case Management is on behalf of the consumer, not to the consumer, and is management of the case, not the consumer.

Health, mental health, addiction, and rehabilitation services

Indiana supports and encourages the use Evidence-Based Practices (EBP). Two examples of this are Assertive Community Treatment (ACT) and Illness Management and Recovery (IMR).

There are 15 CMHCs that are certified by this office to provide ACT. All of those teams are evaluated annually to determine their adherence to fidelity by using the Dartmouth Assertive Community Treatment Scale. Twenty-three CMHCs have implemented some level of IMR with fidelity.

In keeping with DMHA's movement towards a recovery-oriented system of care, the DMHA Office of Consumer and Family Affairs issued a request for proposals in 2009 for Recovery Specialist training and certification. A contract was completed with Affiliated Service Provider of Indiana to provide the training, certification testing and provision of continuing education guidelines and marketing activities related to the program. To date 124 individuals have completed Certified Recovery Specialist (CRS) training and have achieved certification. DMHA is expanding the curriculum to include addiction peer recovery content. The first statewide CRS conference was held in 2010.

Employment services

Indiana recognizes the importance of employment in achieving recovery. DMHA, in conjunction with the Office of Vocational Rehabilitation Services (VRS) established a series of Supported Employment (SE) establishment grants that were instrumental in furthering SE in the state. All CMHCs have supported employment programs with the exception of two and those have working relationships with local VRS offices. To promote positive outcomes, improvement in consumer employment is one of the performance measures by which providers earn payment incentives.

Housing services

While CMHCs provide a range of residential services, safe and affordable independent housing is not readily available for all consumers served in the public behavioral health system. Therefore, we have determined that development of a statewide housing plan will be one of our priority areas. The Indiana Housing and Community Development Authority, in conjunction with the Corporation for Supportive Housing, provided three Housing Institutes. The Institutes are designed to help providers establish new and innovative relationships with local funders of housing and local providers of housing, with the intention of establishing a new dynamic in housing in which the treatment provider focuses on treatment and the housing provider focuses on housing. This has highlighted the benefits of multi-agency efforts to blend funding and to make available necessary recovery supports. A fourth Housing Institute, focused on homeless veterans, is scheduled for this calendar year.

Educational services

Intake assessments address the educational needs and desires of the consumers. The educational desires of the consumers are often coupled with the employment desires. DMHA has worked with other groups in efforts to formalize supported education to be on par with supported employment. The group created a booklet on supported education but our efforts have not equaled that of supported employment.

Addiction services

All CMHCs in Indiana provide mental health and addiction services. In addition, there are four Managed Care Providers providing only specialty addiction treatment and nine other funded specialty addiction providers. Twenty-two of the MCPs and CMHCs are endorsed providers for gambling addiction treatment. Indiana received an Access to Recovery (ATR) grant from SAMHSA in 2007 and again in 2010 to develop and maintain a recovery-oriented network of additional faith and community-based providers in 10 of Indiana's largest counties. ATR may serve as a model for expansion of treatment and recovery support alternatives throughout Indiana in the future. Another SAMHSA grant is assisting to decrease offender recidivism through enhancing community re-entry for individuals with addiction leaving the correction system.

Recovery support services

Per the required Continuum of Care, all providers offer a wide array of recovery support services. Those services will be enhanced by the individuals that are being trained and certified currently as CRS. CRS, ATR and community re-entry projects are charting a course for recovery support services of the future in Indiana and this has been identified as one of four priority areas for DMHA.

Services for persons with co-occurring substance use and mental health disorders

A survey of providers indicated that 14 of the 30 providers have an identifiable dual diagnosis track for consumers. Our data indicate that more than 6,000 persons received dual diagnosis services. Additional focus will be placed in this area to promote the use of EBPs/promising practices directed toward integration of mental health and addiction services. DMHA would encourage SAMHSA to allow integration of the block grant funds in future block grant cycles to target programs for persons with co-occurring disorders.

Other activities leading to reduction of hospitalization

Fifteen providers have ACT teams that are designed to reduce hospitalization. Many CMHCs have adopted IMR and many have made significant moves toward use of a recovery model. Over the past six years, DMHA has lead a process to focus on recovery from serious mental illness and addiction including training and technical assistance emphasizing treatment and recovery as an integrated approach toward assisting individuals in developing and maintaining natural and community recovery supports to achieve a life in the community that is secure, rewarding and responsible. The CRS and ATR projects are examples of DMHA efforts in this area.

Medical and dental services

Integration of primary health care is one of the priority areas identified in this year's plan. While all providers complete health screening, we are confident that better linkage and communication between our system of care and the primary health providers can be accomplished. CMHCs are required by rule to complete a physical health screening with referral for a physical examination

when clinically indicated. For residential care, the administrative rule states that the provider must assist the resident to obtain medical and dental care.

State Hospitals

In support of the comprehensive community mental health and addiction system, Indiana operates five hospitals for adults with serious mental illness and persons committed to the hospitals through the criminal justice system. During state fiscal year 2011, DMHA implemented a transition plan for the state hospitals, reducing long-term inpatient capacity by 30%. This plan required that most persons in Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) be discharged to less restrictive community settings. Short-term alcohol and substance abuse services were removed from the state hospital and this capacity was replaced with two grants to community-based treatment providers. Beds for persons with serious mental illness on civil commitments were significantly reduced at one state hospital which now primarily serves persons on criminal justice commitments.

Criterion 2 – Estimations of Prevalence

Adult Mental Health

State Definition of SMI

Indiana Administrative Code (440 IAC 8-2-2) provides the definition of adults with serious mental illness as follows:

1. The individual is eighteen (18) years of age or older.
2. The individual has a mental illness diagnosed under the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association.
3. The individual experiences significant functional impairment in two (2) of the following areas:
   - Activities of daily living
   - Interpersonal functioning
   - Concentration, persistence, and pace
   - Adaptation to change
4. The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the durational requirement of this clause.

This definition closely parallels the federal definition of serious mental illness and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

Estimation of Prevalence

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of adults with Serious Mental Illness in Indiana. The first method is calculated using the Center for Mental Health Services methodology. The second method is based on the eligibility requirements for the Hoosier Assurance Plan, which established eligibility at or below

200% of the federal poverty level. The prevalence estimates for Indiana adults with Serious Mental Illness are depicted in the following table.

Indiana Adults with Serious Mental Illness
2009 Population Estimates

Eligible for DMHA Services (at or below 200% of FPL)	98,315
CMHS Estimation Methodology	260,783
2009 Indiana Population aged 18 and above	4,829,321

Children and Adolescents with SED

State Definition of SED

In Indiana the Division of Mental Health and Addiction considers children to encompass birth through 17 years of age. The implemented definition of SED is as follows:

1. The child has a mental illness diagnosis under DSM IV.
2. The child experiences significant functional impairments in at least one of the following areas:
   - Activities of daily living,
   - Interpersonal functioning,
   - Concentration, persistence and pace,
   - Adaptation to change
3. The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, children who have experienced a situational trauma, and who are receiving services in two or more community agencies, do not have to meet the duration requirement of this clause.

This definition closely parallels the federal definition of serious emotional disturbance and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

Description of Estimation Methodology

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of children with Serious Emotional Disturbance in Indiana. The first method is calculated using the Center for Mental Health Services methodology, which pertains to youth, aged 9 through 17 only. The second method is based on the eligibility requirements for the Hoosier Assurance Plan, which established eligibility at or below 200% of the federal poverty level. Due to the percentage of children in poverty in Indiana (20% plus 23% between 100% and 200% FPL), the prevalence of SED is significantly higher than for the SMI population. The prevalence estimates for Indiana youth with SED are depicted in the following table.

Indiana Children with Serious Emotional Disturbance
2009 Population Estimates

Eligible for DMHA Services (at or below 200% of FPL and 0-17 years)	79,175
GAF <50 (9-17 years only)	63,340
GAF <60 (9-17 years only)	95,010
2009 Indiana Population aged 9-17 (estimated)	791,746

Youth and Adults with CA

State Definition of Chronically Addicted (CA)

Indiana Administrative Code (440 IAC 8-2-3) provides the definition of persons who are chronically addicted as follows:
An individual who is chronically addicted is an individual who meets the following requirements:

1. The individual may be any age.
2. The individual has a disorder listed as a substance-related disorder in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association (DSM IV).
3. The individual experiences significant functional impairments in two (2) of the following areas:
   - Activities of daily living.
   - Interpersonal functioning.
   - Ability to live without recurrent use of chemicals.
   - Psychological functioning.
4. The duration of the addiction has been in excess of twelve (12) months. However, individuals who have experienced amnesiac episodes (blackouts), or have experienced convulsions or other serious medical consequences of withdrawal from a chemical of abuse, or who display significant dangerousness as a result of chemical use, do not have to meet the duration requirement.

Description of Estimation Methodology for Persons Chronically Addicted (CA)

The Division of Mental Health and Addiction uses two methodologies to determine estimates of Persons Chronically Addicted (CA) in need of treatment services. First using the SAMHSA National Surveys of Drug Use and Health (NSDUH) for 2009 methodology for estimating the prevalence of persons who are Chronically Addicted and in need of treatment, in Indiana there are currently an estimated 491,129 or 7.6% of all 6,432,254 Hoosiers in 2010 in need of treatment. The second method is based on the eligibility requirements for the Hoosier Assurance Plan (HAP), which established eligibility at or below 200% of the federal poverty level. An estimated 26% of Indiana's adult population has incomes at or below 200% of the federal poverty level, indicating the number of persons in need who may be eligible for HAP who are Chronically Addicted at 127,694 persons currently.

Criterion 3 – Children's Services

Children/Youth identified as having Severe Emotional Disturbance (SED)

Demographics:
Geography: The 2010 U S Census reports 1,608,298 Indiana youth less than 18 years old, comprising 24.8% of Hoosiers. About 20% (321,000) of Indiana's children and youth are expected to experience mental health needs with 9% to 13% having significant functional impairments and 5% to 9% (80, 000 to 144,750) experiencing severe functional impairments, meeting the federal definition of serious emotional disturbance. During SFY 2010, a total of 42,387 youth in Indiana between the ages of 0-21 years were receiving behavioral health services by DMHA contracted providers.

Age & Gender: Additionally, 53% of all youth who were served by community mental health and addiction providers were between the ages of birth and 12 years of age. The next largest group was those between the ages of 13-17 years (34%). Finally, 13% of youth receiving services were between the ages of 19-21 years. Boys comprised 57% of all youth served.

Race & Ethnicity: The characteristics of Indiana's growing population can be compared with the profile of youth who receive public services. Eighty-four percent of Hoosiers are Caucasian (US Census, 2010) and 9% are African American, 1.6% Asian , 2% report two or more races, and 6% Hispanic, Approximately 71% of all youth in DMHA services are Caucasian,16% are African American; about 3% reported being from a multi-racial background. Less than 1% of youth are from Native American, Asian, Native Hawaiian or Pacific Islander heritage. Approximately 6% of youth receiving community based mental health services identified themselves as being Hispanic or Latino.

Socioeconomics: Of all 42,837 youth in Indiana between the ages of 0-21 years who receive services through DMHA providers, approximately 85% are on Medicaid. A majority, 77%, live below 100% of the poverty level. Another 21% live between 100%-200% of the poverty level. DMHA provides funding for services to individuals living at or below 200% of poverty or who have Medicaid (including special needs adopted youth). Not included are youth with severe emotional disturbances who live in middle and upper middle income families.

State Hospitals: Indiana has two hospitals that serve youth ages 6-12. One of these hospitals also serves adolescents ages 13-17. Due to the decline in census, part of the state hospital transition plan eliminated adolescent beds at one hospital. DMHA is actively reviewing data surrounding utilization of long-term beds for youth and building capacity within the community through the CA-PRTF and continuing System of Care developments.

Current Initiatives (BG funds):

System of Care Mini-Grants – DMHA has been providing two year $50,000 (per year, total of $100,000) mini-grants to communities in order to build their system of care infrastructure. Since 2000, we have funded 80 counties through these mini-grants. Approximately 60 counties continue to function with some level of Wraparound Services.

Family Involvement Grants – In 2008, DMHA started offering these grants to communities in order to assist with developing the Family/Consumer involvement component of their system of care. The goal was for them to use funds to establish a parent/family support group that is run only by families. The Grants recipients must have been previously funded by a SOC mini-grant. They are for two years with initial year funding of $3,500 and $1,500 for the subsequent year.

Technical Assistance Center – DMHA has funded a Statewide Technical Assistance Center for System of Care since 2002 (Choices, Inc.). The TA Center has provided training, consultation, coaching, newsletter and manual through this contract.

Family Action Network (FAN) of Lake County – DMHA has provided funding to FAN in order to assist communities with development of their parent/family support group and inclusion of family voice, choice and ownership in all levels of system of care infrastructure and development.

Statewide System of Care Conference – This annual conference, which celebrated its 10th anniversary this year, is supported by block grant, federal and state funds. An Indiana provider started the Statewide System of Care conference with federal funds received from SAMSHA (CMHI).

Infant/Toddler Mental Health Consultation – This is a partnership with Riley Hospital for Children to provide clinicians with training for the treatment of emotional and attachment-related issues for parents and their children.

Riley Child and Adolescent Psychiatry Clinic - The contract with the Riley Child and Adolescent Psychiatry Program is intended to support a specialty clinic focused on the psychiatric assessment and treatment of youth with substance use disorders and co-morbid mental health issues.

Current Initiatives (Medicaid or federal funds):

Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant (CA-PRTF) – since 2008, we have served nearly 1,100 children/youth through this demonstration grant. This Grant was authorized under the Deficit Reduction Act and operates under 1915(c) waiver guidelines to provide intensive community-based services to children/youth that would otherwise require psychiatric residential or long-term hospital care. Two significant outcomes have been realized by this initiative: (1) reduced occupancy on children's units at the two state hospitals serving youth and (2) reduced admissions and overall cost for Psychiatric Residential Treatment Facilities for youth.

Trauma and Justice Health Reform Strategic Initiatives - Through the current CMHI cooperative agreement focused on Southeastern Indiana (One Community One Family), efforts are ongoing to transform that area and eventually the entire state to become a trauma-informed System of Care. Training and consultation has been provided by THRIVE, which is the State of Maine's

Trauma-informed System of Care. To date, representatives from THRIVE have presented information at the Statewide Indiana Council of Community Mental Health Centers Conference and at the 10th annual Statewide Systems of Care Conference. One Community One Family is also working with THRIVE to obtain a web-based training for trauma-informed care as well as having local representatives to become trained trainers of trauma-informed care.

Transition Age- Transition to Independence Process (TIP) works with transition-aged youth and young adults (14-29 years old) to assist them in a successful transition into adulthood. One Community One Family has TIP Facilitators and is currently serving transition aged youth through this process.

Current Initiatives for Youth with Substance Use and Mental Health Challenges:

Mental Health Screening for Youth in Juvenile Detention Centers – Since 2006, DMHA has been a standing member of the state-wide advisory board addressing mental health screening and assessment for youth entering juvenile detention facilities. This project is sponsored by the Indiana State Bar Association and includes collaborations with state agencies, juvenile courts, juvenile probation, detention facilities, and universities. A significant finding from data collected through this screening process is that nearly one in three detained youth have significant issues with substance use.

Juvenile Detention Alternatives Initiative (JDAI) – DMHA holds membership on the state-wide Steering Committee for Indiana's JDAI project. JDAI is a comprehensive initiative of eight strategies involving system-wide change in philosophy, practice and policy. There are currently eight (8) counties in Indiana implementing JDAI.

Future Initiatives (Medicaid or federal funds):

System of Care Expansion Planning Grant – DMHA, along with the Department of Child Services (DCS), submitted an application for a System of Care Expansion Planning Grant. This grant will provide funding to support a State level System of Care Governance Board in writing a strategic plan.

1915(i) State Plan Amendment – The sustainability plan for the CA-PRTF Grant includes submitting an application for a 1915(i) State Plan Amendment. The state anticipates serving from 300-500 children or youth through this initiative. The population will include children or youth who have been assessed to need institutional level of care.

Money Follows the Person (MFP) – DMHA is in the process of completing an application for Money Follows the Person (Rebalancing Act). Indiana currently has MFP for the Aged and Disabled population. In partnership with DMHA, Indiana Medicaid plans to add the population "children/youth residing in a PRTF or SOF" to the existing program in order to fund their successful transition into the community from institutional care.

Criterion 4 – Targeted Services (Homeless, Rural, Older Adults)

Homeless

The 2011 Point in Time count showed there were 7,410 homeless individuals counted this past January in Indiana. From that data, 12% were identified as having a serious mental illness and 34% were identified as persons with chronic substance abuse; DMHA believes that these underestimate the prevalence of these disorders in this population. General estimates for the state are that 60,000 persons in any year will experience homelessness.

DMHA receives SAMHSA funding under the PATH grant program which funds twelve mental health centers to provide Homeless Outreach Teams. The PATH teams have focused on the chronically homeless population. The teams are continuing to identify homeless veterans to assure they receive their proper entitlements.

The teams provide the following services:

- Screening and diagnostic treatment services
- Habilitation/rehabilitation services
- Community mental health services
- Staff training
- Case management services
- Supportive and supervisory services
- Residential services
- Referrals for primary health services
- Job training and educational services
- Housing services

All the PATH teams are a part of comprehensive community mental health centers and the full continuum of services are available to persons who are homeless and enrolled in treatment services. All of the PATH sites have a certified ACT team operating in the agency.

The target population for the Mobile Homeless Outreach Teams is the homeless individual who is mentally ill and has problems that require professional intervention. Homeless has been defined as including individuals who:

1. May live on the street, in cars, or in abandoned structures or public places;
2. Are housed in emergency shelters and other places not considered home;
3. Are living with friends or relatives in crowded, unhappy, and stressful circumstances;
4. Are living in deteriorated, unsafe housing, often lacking utilities; or
5. Are involved in support programs without which they would be at high risk of homelessness. Some of these individuals may be "chronic" street people while some are on the streets on an episodic basis.

As part of the PATH grant application, DMHA developed a definition of the “at-risk of homeless population”.

“A person at imminent risk of becoming homeless includes those who are:

1. living with friends or relatives in a sequence of living arrangements
2. living in a condemned building
3. facing an eviction notice
4. in a county jail with no housing available upon release or
5. in a psychiatric inpatient unit with no housing available upon release"

DMHA enjoys a positive working relationship with the Indiana Housing and Community Development Authority. All CMHC's are actively involved in their local planning councils. DMHA has seen increases in the number of funding applications by CMHC's in the annual SuperNOFA for HUD funding for the homeless. These activities underscore the emphasis that providers have placed on serving the homeless in their areas. There are now over 400 units of Shelter Plus Care in the state. This year Indiana was successful in the HUD funding competition, and there are three new projects that are CMHC based that will provide an additional 94 beds for the homeless mentally ill and/or chronic addiction population.

DMHA is on the Interagency Council of the Indiana Housing and Community Development Authority. The council is made up of various agencies that work with the homeless population. A subcommittee of the council, the Homeless Task Force, developed the Indiana plan to end chronic homelessness.

The Corporation for Supportive Housing, working with the Indiana Housing and Community Development Authority, is offering the fourth Housing Institute. The Institute provides targeted training, technical assistance, and pre-development financing options to both new and experienced development teams. This year the Housing Institute will focus on teams that develop housing for homeless veterans.

Teams receive over 80 hours of training including individualized technical assistance and resources to assist in completing their project. In addition, experts from across the state, including staff from the Indiana Housing and Community Development Authority (IHCDA), and national partners provide insight on property management, financing, and building design. One of the goals of the Housing Institute is the creation of over 700 new housing units by 2012.

Rural Services

DMHA has defined rural as those counties with fewer than 100 persons per square mile.

Indiana has several metropolitan areas; Indianapolis, Ft. Wayne, South Bend, Evansville, and the northwest section of Lake County; however, most of the state is rural. Historically, Indiana has maintained a remarkable standing in the provision of mental health and addiction services in rural areas. DMHA tracks the penetration rate of behavioral health services in rural areas. The data indicate that the likelihood of a person receiving services in a rural area is the same as in an urban area.

There is continuing concern about the availability of behavioral health clinicians in many rural areas, especially psychiatrists. Indiana has experienced a decrease in the number of psychiatrists over time and it is increasingly difficult for rural providers to attract psychiatrists. Some providers in rural areas have explored the use of telemedicine to assist those consumers who

have difficulty traveling to the nearest provider. DMHA is also on the advisory board of a HRSA grant that will be providing telemedicine for veterans who have difficulty accessing care at the VA hospitals. By using teleconference capabilities the veterans will be able to have psychiatric consultation at one of five rural CMHCs that will be linked to the Indianapolis VA. The CMHCs, in addition to providing space, will provide staff if a crisis situation arises and a personal intervention is needed.

Older Adults

DMHA is aware of the demands on the system that will be created with the aging of the population. For many years DMHA has required CMHCs to provide services for older adults. Specifically, CMHCs are required to have a plan on how they intend to serve older adults, to designate a contact person for older adult services, and to perform the federally mandated PASRR/MI Level II reviews for individuals with serious mental illnesses applying for admission to Medicaid certified nursing facilities. Two training events for PASRR assessors are provided annually. In addition, a state law requires the centers to work with residential facilities to screen applicants for appropriateness of admission and to develop plans of care for individuals with mental illnesses. The CMHCs also provide a variety of other services, including several who have contracts or arrangements with nursing homes and residential facilities to provide mental health services to residents.

The Division used some Block Grant Funding to host a joint state/national mental health and aging conference in September of 2010. DMHA partnered with the Indiana Mental Health and Aging Coalition, the NASMHPD Older Persons Division, the National Association of PASRR Professionals, and other organizations for the conference.

DMHA provided technical assistance to Adult and Child Mental Health Center which is the recipient of a SAMHSA CMHS Older Adult Targeted Capacity Expansion (TCE) Grant. The purpose of the grant is to implement an enhanced IMPACT program which is recognized as an evidence-based practice. In addition, DMHA used a portion of FFY 2011 Olmstead Mental Health Grant to plan and host a leadership academy to develop older adult mental health consumer self advocacy.

Criterion 5 Management Systems

The DMHA budget for 2012, as passed by the legislature, provides $254.9 million in state funds for DMHA. Of that amount, $117 million is budgeted for CMHC's; $3.9 million is budgeted for DMHA administration; and $134 million is budgeted for the State Hospitals. There is an additional $291 million anticipated in Medicaid funding for behavioral health services.

The majority of Mental Health and Substance Abuse Prevention and Treatment Block Grant funds are allocated to the provider agencies. At the end of a fiscal year this office can track the expenditure of block grant funds to each provider.

Utilization of the Substance Abuse Prevention and Treatment Block Grant funds include 23.29% for primary prevention, 72.71% for treatment, and no more than 5.00% for administration.

DMHA has a long history of providing training for providers in cultural competence. DMHA is nationally recognized as a leader in disaster mental health services and training for disaster responders.

DMHA continues to sponsor training and certification to use the Child and Adolescent Needs and Strengths (CANS) assessment and the Adult Needs and Strengths Assessment (ANSA). Individuals who use the assessment tools must retain certification to use the tools, demonstrating an adequate to high level of inter-rater reliability rating vignettes. Indiana is using a "SuperUser" model, developing local experts, who complete more in depth training regarding how to use information from the assessments and help integrate the tools into every day practice. SuperUsers are supported through annual boosters and ongoing consultation and support. The same training and targeted consultation is provided to behavioral health providers, child welfare staff and providers, participating schools, and auditors.

DMHA is involved in a wide range of training events, many of which are focused on furthering the recovery model and philosophy. Indiana received a Transformation Transfer Initiative (TTI) grant during calendar year 2010 with carry-over into 2011. The objective of this grant was to provide training and technical assistance related to recovery and system transformation for consumers, families, providers and other stakeholders in Indiana. The following is a summary of the activities funded through the TTI grant:

- 34 training and technical assistance recovery/transformation activities were funded by TTI
- Over 3,000 participants were involved in the recovery/transformation activities.
- 7 Regional Town Hall meetings were conducted with 294 individuals participating including consumers, persons in recovery, family members, providers, policy makers and advocates.
- 646 PSAs were aired, titled "What a Difference a Friend Makes."
- 2,889 brochures and "What a Difference a Friend Makes" materials were distributed as of March 1, 2011.
- DMHA conducted surveys to assess readiness of behavioral health providers to implement recovery oriented care. Surveys were completed in March/April 2009 and February 2011 (pre/post TTI). Of the providers who completed both the Pre/Post Provider Readiness Assessment, over 2/3 indicated they had made overall improvement in implementation of recovery oriented principles for consumer services. This improvement was found in all three domains:
    - Recovery
    - Person-Centered Planning
    - Recovery Support Services
- 3 Surveys were used to assess needs and gaps. Information gleaned from the surveys was used to guide decision making for TTI funded training/TA topics.
- Other activities supported by the TTI funds include, but are not limited to:
    - Development and maintenance of a FAQ
    - Development and maintenance of a training website to facilitate registration, share information, and host presentations/materials

- 10 videoconferences were facilitated between DMHA leadership and CMHC leadership to assess recovery oriented care implementation, barriers, and needed resources
- Numerous presentations were developed and delivered to various community stakeholders such as:
    - Consumer/family groups
    - Legislative groups
    - Behavioral health providers

In September 2011, DMHA will sponsor the fourth Indiana Annual Recovery Month Symposium (IN ARMS). IN ARMS includes presentations related to all behavioral health care. Last year over 500 people attended this conference and registration is full for this year. This two day event will include nationally known presenters as well as drawing on a wide range of Indiana based experts. In addition to excellent sessions on evidence-based programs and practices, IN ARMS affords the opportunity for networking and integrating approaches to mental health and addiction recovery strategies.

Behavioral Health Assessment and Plan

Planning Step 1

Assess the strengths and needs of the service system to address specific populations. Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems

The first four narratives in this section provide information about the four priority areas DMHA has selected for the 2012 – 2013 planning cycle. These four narratives are: Mental Health Promotion and Addiction Prevention; Recovery Supports; Safe and Affordable Housing for all Consumers; and Integration of Primary and Behavioral Health Care.

Mental Health Promotion and Addiction Prevention

Indiana may be regarded as a high-need State because of its high prevalence of smoking, high percentage of children in poverty, and low per capita public health funding (America's Health Rankings, 2010). With about 6.3 million residents ("Hoosiers"), Indiana ranks 15th in population and 17th in population density. Since the 2000 census, Indiana's population grew by 4.6%. Indiana is divided into 92 counties, which are predominantly rural. The per capita annual income is $32,288, with the income of the urban population ($33,561) being higher than those of rural inhabitants ($27,790). Of Indiana residents ages 25 and older, 21.6% have a bachelor's degree or higher. The median earning of Hoosiers with a bachelor's degree is $43,243 compared to $27,261 for those with a high school degree or its equivalent.

The median age of Indiana's population is 36.5 years. Indiana's racial and ethnic composition is less diverse than the nation's. The majority of Hoosiers are white (85.8%); 8.7% are black, 1.3% are Asian, 0.2% are American Indian/Alaska Native, 2.4% are some other race, and 1.6% belong to two or more races. In regard to ethnicity, 4.7% are Hispanic/Latino (of any race). An estimated 12.5% of Indiana residents are below the poverty level. Poverty rates are particularly high among blacks (27.1%), Hispanics of any race (22.6%), and children under the age of 18 (17.3%). About 12% of Hoosiers are uninsured, 11% are on Medicaid, and 12% are on Medicare.

Indiana's Epidemiological Outcomes Workgroup (SEOW) was established under the Strategic Prevention Framework grant. The SEOW is comprised of representatives from academia, the State health department, the pharmacy board, tobacco prevention and cessation agency, State police, State department of correction, criminal justice institute, and DMHA staff. The SEOW continues to publish its State Epidemiological Profile on an annual basis, updating all data on consumption and consequences of substance use. This includes a ranking of Indiana counties on the severity/impact of alcohol and other drug abuse, using a highest-need/highest-contributor model. Below are selected findings from the 2010 Indiana SEOW report among other sources:

Risk Factors for Substance Abuse:

Several elevated risk factors have been identified, which make Hoosier youth and adolescents vulnerable to substance abuse and mental health problems. These risk factors include:

- Family Conflict - The divorce rate (2010 estimate) was 11% for the State (Indiana Prevention Resource Center, "Prev-Stat" 2011). This is higher than the U.S. divorce rate of 10%. In 2010, 44.8% of sixth graders, 54.9% of eighth graders, 44.6% of tenth graders, and 38.4%of twelfth graders were considered high-risk for family conflict. Children raised in families high in conflict, whether or not the child is directly involved in the conflict, appear at risk for both delinquency and drug use.
- Economic Deprivation - Low-skill service industry employees have higher rates of methamphetamine use. In 2010, the percentage of employees with low-skill service industry employment in Indiana was 27.8%. This percentage was higher than the U.S. percentage of 22.1.
- Interaction with Anti-Social Peers – In 2010, 51.8% of eighth graders, 56.4% of tenth graders, and 54.3% of twelfth graders were considered high-risk for having peers who engage in antisocial behavior (substance use, illegal behavior). Young people who associate with peers who engage in antisocial behaviors are at higher risk for engaging in antisocial behavior themselves.
- Early Onset of Substance Use – Research shows that those who began drinking before age 14 were more likely to experience alcohol dependence later in life than persons who began drinking at age 21 or older (Hingson, Heeren, & Winter, 2006). The average age of first use across the State in 2010 (both genders combined) was 13.0 years for cigarettes, 13.2 years for alcohol, and 13.9 years for marijuana (Gassman et al., 2010).
- Perceived Harm - Prior research has demonstrated that perceived risk of harm in using drugs is negatively related to prevalence of use (Gassman et al., 2010; Millstein & Halpern-Felsher, 2002; Wild, Hinson, Cunningham, & Bacchiochi, 2001).

    - Enforcement/Perceived Risk of Arrest. Williams & Hawkins, (1986) and later, Nagin & Paternoster, (1991) address the link between perceived risk of arrest and likelihood of offending—if sanctions are swift and severe, or likely to cause stigma, the less an individual is likely to offend.
    - Alcohol: Beginning July 1, 2010 all persons purchasing alcoholic beverages in Indiana were required to show identification. The results of the Survey for Alcohol Compliance shows that the sales to minors decreased after the law took effect. Unfortunately, in the most recent legislative session the law was changed to requiring carding only for those who "reasonably" look 40 or younger (Indiana State Police, 2011).
    - Methamphetamine: A State law enacted July 1, 2005 (Senate Enrolled Act 444) requires retailers to keep medications containing ephedrine or pseudoephedrine (key ingredients in the manufacturing of methamphetamine) behind a counter. The restrictions may have contributed to the decline in Indiana methamphetamine lab seizures through 2007; however the rate has begun to climb in the past three years, possibly as users have found ways around the medication restrictions.

Substance Use:

Substance use among Hoosiers continues to be an issue requiring a responsive and effective prevention system. Data relating to alcohol and prescription drug abuse and its consequences are discussed below.

Alcohol:

Alcohol is the most frequently used drug in Indiana and the United States.

- Among Hoosiers ages 12 and older, 49.3% (2.6 million residents) drank alcohol in the past month, and 23.0% (1.2 million residents) engaged in binge drinking. (Substance Abuse and Mental Health Services Administration (SAMHSA), 2010).
- Young adults ages 18 to 25 old had the highest rates of alcohol use in Indiana: 58.2% reported current alcohol use and 40.3% reported binge drinking. (SAMHSA, 2010).
- Rates for heavy drinking were significantly lower in Indiana than in the United States (IN: 3.7%; U.S.: 5.1%). (CDC, 2010a)
- Among Hoosiers 12 to 20 years old, 25.5% reported current alcohol use and 17.4% engaged in binge drinking. (SAMHSA, 2010).
- 15.7% of Indiana youth ages 12 to 17 drank alcohol in the past month, and 9.9% engaged in binge drinking. (SAMHSA, 2010).
- 38.5% of Indiana high school students (grades 9 through 12) used alcohol in the past month, and 24.9% engaged in binge drinking. (CDC, 2011).
- 14.9% of 8th graders, 30.4% of 10th graders, and 43.5% of 12th graders consumed alcohol in the past 30 days. (Gassman, et al., 2010).
- The annual rate for alcohol abuse and dependence in Indiana was 6.9%, with the highest rate among 18- to 25-year-olds (16.5%). (SAMHSA, 2010).
- Most admissions to substance abuse treatment were due to alcohol abuse, and the percentage of admissions for alcohol dependence was significantly higher in Indiana (47.3%) than in the U.S. (41.3%). (SAMHSA, 2008).
- The percentage of treatment episodes in Indiana in which alcohol dependence was indicated was lowest among blacks (38.4%); in roughly half of all treatment admissions among whites and among other races, alcohol dependence was reported. (SAMHSA, 2008).
- From 2000 through 2006, a total of 2,284 Hoosiers died from alcohol-induced causes. (Indiana State Department of Health. (2010a). The age-adjusted alcohol-attributable mortality rate in 2006 was 5.0 per 100,000 Indiana residents. (CDC, 2010b).
- Alcohol is a common factor in drowning accidents (34%) and suicides (23%). (CDC, 2004).
- In 2006, nearly 400 Indiana mothers used alcohol during their pregnancy. (Indiana State Department of Health, 2010b)
- In Indiana, the number of alcohol-related collisions decreased from 13,911 in 2003 to 8,855 in 2009. Also, the number of fatalities in crashes attributable to alcohol declined from 242 to 157 during those same years. The 2009 overall annual rate for alcohol-related collisions in Indiana was 1.38 per 1,000 population. (Indiana State Police, 2009).

- Indiana's 2008 arrest rates per 1,000 population for alcohol-related infractions were significantly higher than the nation's. This included arrests for driving under the influence (IN: 4.9; U.S.: 4.2), public intoxication (IN: 3.5; U.S.: 1.7), and liquor law violations (IN: 2.7; U.S.: 1.8). (Consortium for Political and Social Research, 2010).

Prescription Drug Abuse:

The three most commonly abused types of prescription medicine are pain relievers (opioids), central nervous system depressants (sedatives, tranquilizers, hypnotics), and stimulants (used to treat attention deficit disorders, narcolepsy, and weight loss). (*NIDA, 2005).*

- In 2008, 11.5 million prescription drugs (controlled substances), primarily pain relievers (6.1 million), were dispensed to Indiana residents. (Indiana Board of Pharmacy, 2010).
- Among Hoosiers age 12 and older, 2.7% (138,000 residents) reported current (past-month) abuse of psychotherapeutics, 7.6% (383,000 residents) abused them in the past year, and 21% (1 million residents) abused them at least once in their life. (SAMHSA, 2010).
- Past-year prevalence for nonmedical pain reliever use in Indiana residents ages 12 and older was 6.0%, significantly higher than the U.S. rate of 4.9%. Young Hoosiers ages 18 to 25 had the highest rate of past-year use (14.2%). (SAMHSA, 2010).
- In 2008, law enforcement made over 3,500 arrests for possession and over 800 arrests for sale/manufacture of "other drugs" in Indiana; representing arrest rates of 0.6 and 0.1 per 1,000 population, respectively. (Consortium for Political and Social Research, 2010).

Mental Illness:

Of Indiana's approximately 6.4 million residents, close to 227,000 adults live with serious mental illness and about 71,000 children live with serious mental health conditions (NAMI, 2010).

- In 2009, 17% of women in Indiana reported poor mental health on 8 or more of the past 30 days, greater than the rate for all U.S. women (16.2%).
- In 2007, the Annie E. Casey Foundation reported that 18% of Indiana children (individuals under the age of 18) have been diagnosed with one or more emotional, behavioral, or developmental condition. The rate of diagnoses in Indiana was greater than the U.S. rate of 15% of children with these conditions.
- Compared to all States in 2007, Indiana had the 36th highest rate of children with one or more emotional, behavioral or developmental condition (Annie E. Casey Foundation-Kids Count, 2009)
- The 2009 Youth Risk Behavior Survey (YRBS) reported that Indiana students in grades 9-12 reported high rates of prolonged feelings of sadness or hopelessness, risk factors for mental health conditions. In 2009, 28% stated that they felt sad or hopeless almost every day for at least two weeks during the past 12 months.
- Indiana's public mental health system provides services to only 15 percent of adults who live with serious mental illnesses in the State (NAMI, 2010)
- The National Alliance on Mental Illness compiled report cards for the individual States of the US with regards the Public Adult Mental Healthcare System. Indiana was given a D- in this assessment and the State's urgent needs were identified as the need for caution on

scope and speed of changes, greater transparency, consumer and family participation in decisions, and waiting list reduction for community services (NAMI, 2006).

- In 2007, the National Center for Injury and Prevention (NCIP) received 790 reports of deaths from suicide from the State of Indiana. The 2007 age-adjusted rate for deaths from suicide in Indiana was 12.37 deaths per 100,000 deaths. This rate is higher than the 2007 national rate of deaths from suicide (11.27 per 100,000 deaths). The State rate of deaths from suicide has been higher than the national average for nearly a decade (CDC WISQARS, 2011).
- In 2007, Indiana crude rates of death from suicide were higher than the U.S. rates in all age categories except for 45-49 years, 55-64 years, and 80+ years.
- Results from the 2009 YRBS reported that Indiana adolescents were more likely to have attempted suicide resulting in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (3.6%), than both the 2007 Indiana percentage (2.9%) and the 2009 U.S. percentage (1.9%).
- The 2009 YRBS also reported that 17% of Indiana adolescents thought seriously about suicide, 14% made a suicide plan, and 9% attempted suicide; these results are much greater than the results for U.S. adolescents of 13.8%, 10.9%, and 6.3%, respectively.

Current Initiatives (SAPT BG funds):

- Prenatal Substance Abuse Prevention Program (PSUPP), Indiana State Department of Health
- Leading and Educating Across Domains (L.E.A.D.) Initiative, Geminus Corporation (RFP 9-83)
- Addiction Technical Assistance Center, Indiana Prevention Resource Center at IU-Bloomington (RFP 9-42)
- Indiana Coalition to Reduce Underage Drinking (ICRUD), Mental Health America of Indiana
- State Alcohol Compliance (SAC)Program, Indiana Alcohol and Tobacco Commission/Indiana State Excise Police
- Indiana State Epidemiological Outcomes Workgroup (SEOW), Indiana University-Purdue University at Indianapolis (RFP 9-43)
- Communities that Care (CTC), 14 Primary Contractors (RFP 9-40)
- Afternoons R.O.C.K. in Indiana***, 14 Primary Contractors (RFP 9-40)

Current initiatives (non Block Grant Funds):

- Problem Gambling Training and Awareness, Indiana Prevention Resource Center at IU-Bloomington
- Type II Gaming Compliance, Indiana Alcohol and Tobacco Commission/Indiana State Excise Police
- Tobacco Retailer Inspection-SYNAR/Tobacco Retailer Inspection Program (TRIP), Indiana Alcohol and Tobacco Commission/Indiana State Excise Police

Future Initiatives (non-block grant funds):

- Implementation of the recently awarded State Prevention Enhancement (SPE) Grant

- End current Afterschool Programming Format-December 2012
- Develop a statewide plan for prevention
- Prevention Prepared Communities

As the information and data on these pages reflect, mental health promotion and addiction prevention are very high priority areas for Indiana. Therefore, they have been identified on Tables 2, 3, and 10.

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Recovery Supports

DMHA's primary objective for all persons is full access to all services and supports that will assist them in their recovery journeys. Most of the planning activities within this State Plan for 2012 – 2013 revolve around this objective. Treatment services at the right time and in the right amount will be essential to support the person's recovery. However, treatment alone is not sufficient. Persons with mental illness and/or addiction can be supported in their recovery by:

- safe, affordable, and accessible housing that is fully integrated within the community
- opportunities for gainful employment
- social networks
- educational, recreational, and spiritual access

Consumer-operated businesses can provide an opportunity for recovery support and community inclusion. DMHA has recently utilized mental health block grant funds to support the start-up of two consumer-operated businesses and one continuing consumer-directed activity. KEY Consumer Organization has received mental health block grant funds for several years to work with consumers interested in establishing local consumer advocacy organizations. Family Action Network has received mental health block grant funds to develop self-sustaining family support groups in communities that have established a System of Care. NAMI has received mental health block grant funds to provide peer-to-peer and family-to-family training.

Non-traditional services and supports have been used by the Access to Recovery (ATR) grants from SAMHSA and the Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) demonstration grant from CMS. Data is beginning to demonstrate that these non-traditional services and support may be having a positive impact on a person's recovery outcomes. For this priority area, State planning activities during 2012 – 2013 will further examine these supports for the purpose of identifying a set of services and supports that should be available to all persons accessing the public mental health and addiction system. Since these are non-traditional services, they are currently available to a small number of persons in Indiana. If these services are found to be effective based on the planning cycle data collection and analysis, DMHA will then identify administrative actions that can lead to broader adoption.

A sampling of ATR Non-Traditional Services includes the following:

- Community Based Continuing Care
- Emergency Housing
- G.E.D. Test
- Group Community and/or Faith Based Support
- Group G.E.D. and Supportive Education
- Group Parenting Education
- Individual Community and/or Faith Based Support
- Individual G.E.D. and Supportive Education
- Individual Parenting Education
- Parenting Support Services - Respite Child Care

- Peer Coaching
- Transitional Housing Assistance
- Transportation Agency Vehicle
- Transportation Bus/Van/Cab - ticketed/billed

A sampling of CA-PRTF Non-Traditional Services includes the following:

- Wraparound Facilitation
- Consultative Clinical and Therapeutic
- Training and Support for Unpaid Caregivers
- Habilitation
- Respite
- Non-Medical Transportation

Recovery Supports has been identified as a priority area for the 2012-2013 planning cycle. The goal, strategies, and performance indicators are on Tables 2, 3, and 10

Safe and Affordable Housing for All Consumers

When asked what contributes to their recovery journey, one of the over-arching needs given by consumers is safe, affordable, and accessible housing which is integrated within the community. DMHA believes that this is an area of the consumer's life that requires consistent coordination between the consumer, the consumer's family and friends (when possible), the behavioral health care provider, and the individuals and organizations within the community that provide housing. To the greatest extent possible, consumer choice must drive where to live and with whom to live.

While CMHCs provide a range of residential services, safe and affordable independent housing is not readily available for all consumers served in the public behavioral health system. There exist many housing initiatives across the state and varying amounts of available housing stock depending on the area of the state in which the consumer lives. This leads to difficulty in locating housing that appeals to the consumer and connecting with on-provider landlords who are accepting of persons with behavioral health challenges. Therefore, DMHA has determined that development of a statewide housing plan will be one of our priority areas for 2012 - 2013.

Indiana has made positive strides toward developing partnerships within a community that are intended to lead to housing options for the consumers. The Indiana Housing and Community Development Authority, in conjunction with the Corporation for Supportive Housing, provided three Housing Institutes. The Institutes are designed to help providers establish new and innovative relationships with local funders of housing and local providers of housing, with the intention of establishing a new dynamic in housing in which the treatment provider focuses on treatment and the housing provider focuses on housing. This has highlighted the benefits of multi-agency efforts to blend funding and to make available necessary recovery supports. A fourth Housing Institute, focused on homeless veterans, is scheduled for this calendar year. Efforts were also made to further define a supportive housing model. Specifically, supportive housing services were cross-walked to Medicaid covered services. This led to the identification of those supports that may require DMHA funding.

Safe and Affordable Housing has been identified as a priority area for the 2012-2013 planning cycle. The goal, strategies, and performance indicators are on Tables 2, 3, and 10

Integration of Primary Health Care and Behavioral Health Care

Integration of primary health care and behavioral health care is acknowledged as the next step in the evolution of a good and modern mental health and addiction treatment and services. This acknowledgement comes from the recommendations of the President's Commission on Mental Health, the Institute of Medicine, the analysis of death records of persons with serious mental illnesses, and the passage of parity legislation by the U.S. Congress. Integration of primary health care applies to all populations served by DMHA and is a high priority for the State.

All certified providers in Indiana are required to provide a continuum of care that includes screening and linkage for physical care. The provision of that care varies. In many cases there is a referral to a physician but there is little or no communication back to the provider. In many other instances a consumer may see their own physician or several physicians and there is no communication and coordination of care. There is a need to promote best practices that move our system to become integrated and integral to the provision of physical health care.

Approximately two years ago, the Indiana Mental Health and Addiction Transformation Workgroup convened a subcommittee to make recommendations for integration of primary health and behavioral health care best practices. A full literature review identified the following issues related to primary health care for persons with mental illness and/or addiction:

- About half of US Population will meet criteria for a DSM-IV diagnosis in their lifetime; slightly over a quarter of the population in a year's time.
- Half of all mental disorders begin by age 14 and three-fourths by age 24.
- Most people with mental disorders are untreated. For those in treatment, more than half receive less than adequate care.
- Over half of those who receive treatment for their disorders do so from a general medical provider.
- Psychosocial factors drive 70% of all healthcare visits.
- Of all mental health care, 50% is provided in the primary medical care setting.
- Of psychotropic prescriptions, 67% are prescribed by primary care providers. Of antidepressants, 80% are prescribed by primary care providers.
- Factors prompting integration include failure of referrals and medical co-morbidities and premature mortality of the severe mentally ill.

<u>Indiana Models</u>
Several different models are utilized throughout Indiana including, but not limited to:

- The Primary Medical Provider (PMP) co-locates with a local behavioral health provider for a psychologist, therapist, and/or clinical Licensed Social Worker on site at the PMP's office.
- PMP sees patients at the local mental health center.
- The PMP refers patients to the behavioral health provider who is located at a different location than the PMP.

There are pros and cons for each of these as well as varying degrees of successful integration. The Transformation Workgroup highlighted these issues. The primary strength related to integration of primary and behavioral health care in Indiana is that many primary care providers and many behavioral health care providers have recognized the importance of integration and have implemented initiatives to address integration.

The most significant need related to integration of primary and behavioral health care in Indiana is the lack of any consistency in defining and implementing "integration models" across the state and the lack of a common mechanism/methodology to assess and monitor effectiveness.

Strengths

- Three providers are recipients of SAMHSA grants to provide integrated primary and behavioral health care.

- One provider is exploring the provision of primary health care on site and has hired two general practitioners to operate a clinic at their main center.

- DMHA has established dialogue with other agencies regarding Health Information Technology and is participating on the State HIT committee.

Even though DMHA has gathered information on the "state of the state", we are in the preliminary stages of integration of health care. DMHA plans to convene a workgroup to steer the state's efforts in this area.

Integration of health care has a significant information technology component. Indiana's current status related to this technology is in the narrative for Data and Information Technology. The use of health information technology (HIT), electronic health records (EHR), health information exchanges (HIE), regional extension centers (REC) and other technology/ organizations will be critical aspects for successful integration. Health information is a growing field which can appear very complicated to the uninitiated. A few action steps have been identified for the near term in order to gather more information about information technology aspects of integrated primary and behavioral health care.

Recommended Action Steps for Information Technology

- Continue a dialogue with IHIT - Indiana Health Information Technology, including both the state hospitals and community health information.

- Maintain contact with the three providers (Adult & Child, Centerstone, Southlake [Regional]) that have received a SAMHSA grant to provide integrated primary and behavioral health care. (What is working? What have they learned? How can the Division support future integration?)

- Create a follow-up survey that would provide information about their systems and their activities related to integrating with primary care.

- Meet with the two Regional Extension Centers and identify how DMHA can become involved and support these efforts.

Integration of primary and behavioral health care has been identified as a priority area for the 2012-2013 planning cycle. The goal, strategies, and performance indicators are on Tables 2, 3, and 10.

Intravenous Drug Use (IVDU)

Current Services Summary

The State of Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) encourages and prioritizes the admission into treatment for persons with a history of intravenous drug use (IVDU) in order to help prevent the spread of blood borne communicable diseases such as hepatitis, Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS). Managed Care Providers (MCPs) for treatment services for chronic addiction (CA) participate in capacity monitoring and reporting, priority admissions for persons with IVDU, and outreach to this specific group, through contractual requirements. In addition, DMHA also has a Memorandum of Understanding (MOU) with the Indiana State Department of Health (ISDH) for IVDU outreach as part of an ISDH overall program of community outreach and communicable disease prevention and intervention.

MCPs are required to notify DMHA upon reaching ninety percent (90%) of capacity by Contract Special Conditions Requirements. Since MCPs provide crisis and outpatient services, they no longer operate with a stated capacity. Therefore, notification has not been made in recent years. However, notification is still required if 90% capacity is reached.

MCPs are required to admit a person with IVDU within fourteen (14) days of request for admission, provide interim services within forty-eight (48) hours of such request and be admitted within 120 days of the original request, by Contract Special Conditions Requirements. However, since MCPs provide crisis and outpatient services and agree to provide priority admission to persons with IVDU, admission is not longer than fourteen (14) days in such cases. Priority admission order is:

1. Women who are pregnant and with IVDU;
2. Women who are pregnant;
3. Persons with IVDU;
4. All others.

MCPs are required to participate in outreach activities aimed at individuals and their associates considered high risk for substance abuse. The outreach model used shall be scientifically sound, or if no such model is available which is applicable to MCP's local situation, each shall use an approach which reasonably can be expected to be an effective outreach method. The model shall require that outreach efforts include the following: 1) selecting, training, and supervising outreach workers; 2) contacting, communicating with, and following up with high-risk substance users, their associates and neighborhood residents, within the constraints of federal and state confidentiality requirements, including 42 CFR Part 2; 3) promoting awareness among injection drug users about the relationship between injection drug abuse and communicable diseases such as HIV; 4) recommending steps that can be taken to ensure that HIV transmission does not occur; and 5) encouraging entry into treatment. ISDH has similar requirements to provide outreach to persons with IVDU statewide as needed.

Intravenous Drug Use (IVDU) Assessment

According to the Statewide Epidemiological Outcomes Workgroup (SEOW) reports, Indiana does not have specific data on IVDU. A March 2010 Indiana University – Purdue University at Indianapolis (IUPUI) Center for Health Policy report estimated 10,800 persons injecting drugs. Updating for 2010, the United States Census for Indiana was 6,432,254. Substance Abuse Mental Health Services Administration (SAMHSA) currently estimates that 7.64% of all individuals are in need of treatment for addiction at any one moment in time. Using the SAMHSA estimate, approximately 491,129 Hoosiers are in need of addiction treatment today. SAMHSA also estimates that 0.17% of Americans age 12 and older have used drugs intravenously in the past year. Using the SAMHSA estimate, approximately 9,200 Hoosiers have used drugs intravenously in the past year. In State Fiscal Year 2010, 2,503 persons with IVDU were treated for chronic addiction, a 27% penetration rate in the total estimates of current persons with IVDU.

Since IVDU is rarely an early experimental step in drug use, and is often a sign of progression of addiction to cocaine, opiates, methamphetamine, and other sedative drugs, including illicit use of prescription drugs, this would indicate that 1.89% of Hoosiers are in need of treatment for addiction with IVDU. This relatively low percentage is a result of the fact that most people use alcohol, tobacco and/or marijuana which are almost never used intravenously. And, the drugs used intravenously are not frequently used, such as current use of cocaine at 0.7%, methamphetamine at 0.2% and heroin at less than 0.01%, according to the SEOW report, *Consumption and Consequences of Alcohol, Tobacco, and Drugs in Indiana: A State Epidemiological Profile 2010*.

Intravenous Drug Use (IVDU) Strengths

Certainly a major strength in Indiana's strategies in addressing intravenous drug use is the cooperative and collaborative approach of Managed Care Providers, Indiana State Department of Health, and Indiana Division of Mental Health and Addiction, as evidenced by the estimate that over one out of four persons with current IVDU were treated for chronic addiction during the past year.

Intravenous Drug Use (IVDU) Needs

While the assessment above offers reasonable estimates and factors, these are only estimates in the absence of specific data and methodologies. Things needed to improve services in Indiana to persons with IVDU include a need for actual baseline and ongoing Indiana specific data on IVDU, more varied Evidenced-Based Practices (EPBs) on outreach, intervention and treatment of persons with IVDU particularly in rural and other regionally specific groups, outreach methods, including EBPs for outreach in rural areas and specific groups such as youth, GLBTQ individuals, and relative outcome data for persons with and without IVDU.

Children at Risk, Adolescents with Substance Use and Mental Health Challenges, and Transitional Age Youth

DMHA considers the child and adolescent services and programs that have developed across the State to be a primary strength of the system. Systems of Care offering wraparound services are available in most communities. Indiana has been the recipient of three SAMHSA Child Mental Health Initiative grants. Indiana has worked with the Centers for Medicare and Medicaid (CMS) to develop Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) with five years of Medicaid funding. DMHA is also involved with other State agencies and public entities to improve the social, emotional, and behavioral health of youth in Indiana. (See details in the section for Criteria 3.)

Two significant outcomes have been realized through these efforts:

- Reduced occupancy on children's units at the two state hospitals
- Reduced admissions and overall cost for Psychiatric Residential Treatment Facilities

Currently, there remain several concerns about the youth in Indiana. Some of these concerns are:

- High rates of suicide
- Lack of statewide trauma informed care programs
- Poor outcomes for youth involved with serious substance use
- Inadequate services for, and engagement of, youth transitioning from adolescents to adulthood

Each of these areas has been addressed through high level planning activities. Although actual implementation of programs and services to directly address these areas will be long-term, DMHA is committed to continuing the dialogues and planning activities that will lead to successful outcomes.

Pregnant Women and Women with Dependent Children

Programming Strengths

- DMHA is involved in the Prenatal Substance Abuse Cross Agency Committee (PSACAC) with the Office of Medicaid Policy and Planning, Indiana Tobacco Prevention and Cessation, the Indiana State Department of Health, The Indiana Perinatal Network, and First Steps. PSACAC is working on the development of a framework for addressing prenatal substance abuse across systems.
- The Prenatal Substance Use Prevention Program (PSUPP) is a three-tier prevention program administered by the Indiana State Department of Health and funded by the Indiana Division of Mental Health, the Indiana Tobacco Prevention and Cessation Program, and the Maternal and Child Health Services. The goal of this program is to prevent poor birth outcomes, by attempting to encourage women who are pregnant to decrease or eliminate alcohol, tobacco and other drug use.
- SAPT Block grant funds are used to support six residential programs for women that are pregnant and have dependent children.
- SABT Block Grant requires a Maintenance of Effort (MOE), minimum obligation of funding, of $2,775,760 for treatment of pregnant women and women with dependent children. In SFY 2009 Indiana spent $3,584,695, $808,935 more than the required MOE. In SFY 2009 3,200 women and/or women with dependent children, including 287 pregnant women received services. This results in an average allocation of $1,120.22 per consumer.
- Indiana's Access to Recovery grant serves the target population of women who are pregnant or have dependent children in ten counties. This has allowed DMHA to work at the state and community level with agencies like the Department of Child Services and the State Department of Health who provide programs and services that either serve or include parents who have a substance use problems or disorders.

Gaps/Needs

- There is a need for additional training and technical support for evidence based gender specific treatment and interventions to be delivered to pregnant women and women with dependent children. Providers to be trained on core competencies as outlined by SAMHSA- "Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals".

Parents with substance use and/or mental health disorders that have dependent children

Indiana Access to Recovery (INATR) is a four year federal grant which was awarded to DMHA in October 2010 by SAMSHA. INATR assists clients who want to get in recovery from substance use problems and disorders or need assistance maintaining their recovery. INATR pilots a recovery-oriented approach to care and helps clients gain access to a network of clinical, community and faith-based organizations who provide treatment and recovery support services to eligible individuals. INATR currently offers parenting support including respite care and family and/or marital counseling which have a parenting component.

Parenting support provides services that help alleviate roadblocks to the client's recovery caused by a lack of child care which hinders their ability to engage in substance abuse treatment and recovery support services. Such services might include respite care, baby-sitting, and limited day-care. Family and marital counseling provides personal, spousal, and full-family counseling tailored specifically to the issues identified in an in-depth assessment that relate to the client's recovery and the effects their use has had on their family members. Services provided should engage the entire family system to address issues such as interpersonal communication, co-dependency, conflict, marital issues and concerns, parenting issues, family reunification, and strategies to reduce or minimize the negative effects of substance abuse on the relationships.

SFY 2011 169 clients received parenting support and family and marital counseling services through INATR.

Military

With nearly 15,000 National Guard members, Indiana has the fourth largest National Guard in the nation. Because of the wars in Afghanistan and Iraq, members of the National Guard have been called up for service in unprecedented numbers, creating unusual stress for service members and their families. Approximately three-fourths of Indiana National Guard members have been deployed to a theatre of operation (combat, disaster, or humanitarian) at some point in their career. Although National Guard service members have the highest rate of positive drug screens of all the military branches, they do not receive insurance and are only temporarily eligible for VA benefits in the period immediately following deployment. According to published data, the Indiana National Guard members have the third highest positive drug screen rate among all States and U.S. territories, at 5.11%.

To begin addressing the needs of veterans for behavioral health care, the Indianapolis Veterans Administration (VA) sponsored a kickoff event in 2010 that included DMHA. The VA is developing an initiative to identify and provide outreach to homeless veterans. DMHA has staff assigned to be the liaison for veterans' issues. That person is responsible for establishing and maintaining contact with the VA and other agencies related to veterans and military families.

DMHA is represented on the advisory board of a newly funded HRSA grant, Indiana Veteran's Behavioral Health Network that will establish five telemedicine sites that are linked to the Indianapolis VA to provide remote psychiatric consultation. This board consists of several agencies that relate to military issues and will serve to promote a better working relationship between DMHA and those agencies.

We are also a partner in STAR Behavioral Health Providers which is an effort to provide training of counselors so they will be better able to respond to the issues of those in the military and their families. They offer three tiers of training. Those trained will be listed on a registry of so military consumers can locate a provider who can meet their needs.

DMHA presently tracks veteran's status in our data base. The assessment tool providers are required to use includes questions about military, veteran's status, combat, and present military status. DMHA does not presently collect information on military families; consideration is being given to add an assessment question and data entry item.

Recent site visits for the PATH grant revealed that the CMHC's in the state have a good relationship with the various local VA offices and regional VA hospitals. As the VA becomes more active in the provision of behavioral health for former service personnel DMHA needs to make sure the VA is aware of the services we have to offer. As DMHA continues to fund services to those that may be on active duty in the Guard and to fund services for families of active duty Guard members we need to assure proper identification of military related issued in order to provide the best possible supports and treatment protocols.

Indiana Access To Recovery Operation Immersion was held April 19th -21st at Camp Atterbury in South Central Indiana. The Indiana National Guard partnered with ATR to make

accommodations and trainers available to complete this event. During Operation immersion ATR Provider Staff had the opportunity to experience life as a soldier and to gain a better understanding of the military culture and the challenges that military personnel face regarding substance abuse. Twenty seven agencies sent staff to this training event. The assessment protocol for the Access to Recovery program includes questions about military service and participation in combat.

At this time we feel we are in the early stages of working with the many groups involved in relating to the military and military families. Gaining more information about military families is an identified gap. Efforts through partnerships and enhancing DMHA data collection will be used to fill this gap.

American Indians and Alaskan Natives

The total American Indiana/Alaskan Native population in Indiana is 0.3%. The largest increase among Indiana's population has been among Hispanic/Latinos that make up 6% of the population. The fastest growing minority are Asians at 1.6% of the population. Additionally, Indiana has the third largest population of Amish in the United States with 19 settlements representing a population of more than 35,000.

A portion of the 0.3% American Indian/Alaskan Native population is made up of the Miami Nation of Indiana. The Miami's are not a federally recognized tribe. Legislation was introduced in the 2011 session of the Indiana General Assembly to confer state recognition on the Miami Nation but the bill died in committee without receiving a hearing.

The Pokagon Band of Potawatomi Indians is a federally recognized tribe of 3,150 members. The land held by the tribe in federal trust is all located in Michigan and the tribal government is located in Dowagiac, Michigan. The tribe considers the Pokagon Homeland to be made up of four counties in southwest Michigan and six counties (LaPorte, St. Joseph, Elkhart, Starke, Marshall and Kosciusko) in northwest Indiana.

The Pokagon own and operate the Four Winds Casino Resort in New Buffalo, Michigan and the new Four Winds Hartford which is scheduled to open in the late summer of 2011.
The Pokagon Band Behavioral Health Services is licensed by the State of Michigan to provide outpatient counseling for mental health and substance abuse.

Due to the tribal government and services being based in Michigan the Indiana Division of Mental Health and Addiction (DMHA) has not had a relationship with the Pokagon Band of Potawatomi Indians.

However, DMHA is in the process of identifying the proper contact in the Pokagon tribal government to ascertain the willingness of the tribe to consult in the ongoing development of the SAPT Block Grant plan. Additionally, this could include invitations to participate as a member of the State Epidemiological Outcomes Workgroup (SEOW) or the Mental Health and Addiction Planning and Advisory Council (MHAPAC).

There are no gaps or needs have been identified at this time with this population.

HIV/AIDS, TB and Other Diseases Current Services Summary

Division of Mental Health and Addiction (DMHA) has a Memorandum of Understanding (MOU) with the Indiana State Department of Health (ISDH) for IVDU outreach as part of an ISDH overall program of community outreach and communicable disease prevention and intervention. ISDH has a baseline and ongoing Indiana data specific to intravenous drug use (IVDU). IVDU data is collected through the Division's Office of Clinical Data and Research (OCDR) as case reports of new infections submitted from various service providers. The Special Populations Support Program (SPSP) also collects various demographic and substance use data, including IVDU risk, during outreach, risk assessment, and testing activities. Additionally, some IVDU data is collected through general prevention and testing activities that are provided through the Division. According to the various sources, here is a snapshot of IVDU risk in 2010:

General Prevention - **17,406** persons were tested. **554** reported IVDU within the last 12 months while an additional **329** reported IVDU more than 12 months ago. This represents **5.1%** of all tests performed.
SPSP Testing – **5,839** persons were tested. **1,432** reported IVDU, representing **37%** of all tests performed.
OCDR - **533** new HIV-positive cases were reported in 2010. **35** reported IVDU as risk, representing **6.6%** of all new positives.

All SPSP vendors have been trained extensively in the areas of Harm Reduction and Motivational Interviewing. Harm Reduction strategies are taught during the course of outreach, testing, and supportive care activities. Motivational Interviewing is utilized to improve adherence to care plans and to encourage behavior change that might be beneficial to the client. Additionally, referrals are made to various treatment providers that may use other evidence based practices that are individualized to the client. Both Harm Reduction and Motivational Interviewing are accepted EBPs for behavior change. For Harm Reduction, please refer to *State of the Art in Harm Reduction Psychotherapy: An Emerging Treatment for Substance Misuse* Journal of Clinical Psychology: In Session, Vol. 66 (2), 117-122 (2010). For Motivational Interviewing, refer to The Center for EBP at *Case Western Reserve University-Mandel School of Applied Sciences and Department of Psychiatry, School of Medicine.*

SPSP outreach activities are conducted in various venues including geographically diverse DMHA-licensed drug treatment facilities, jails, drug courts, probation offices, homeless shelters, and other locations where the target population can be found. Due to the very nature of substance abuse, a highly diverse mix of individuals are encountered including, but not limited to, youths, gay, lesbian, bi-sexual, and transgendered people. Because the SPSP grantees are typically agencies that have worked in the HIV service arena for years, they are very gay-friendly and well known in their respective communities for serving this population.

HIV/AIDS, TB and Other Diseases Strengths

Certainly a major strength in Indiana's strategies in addressing HIV/AIDS, TB and other diseases is the cooperative and collaborative approach of Indiana State Department of Health, Indiana

Division of Mental Health and Addiction, and Managed Care Providers, as evidenced by the estimated of numbers of persons with substance use disorders and IVDU participating in the ISDH services and reporting.

HIV/AIDS, TB and Other Diseases Needs

While the assessment above offers reasonable estimates and factors, these are only estimates in the absence of specific data and methodologies. Things needed to improve services in Indiana to persons with HIV/AIDS, TB and other diseases include a need for actual baseline and ongoing Indiana specific data on incidence in the general population, more varied Evidenced-Based Practices (EPBs) for outreach, intervention and treatment of persons with substance use disorders, including IVDU, particularly in rural and other regionally specific groups, outreach methods, including EBPs for outreach in rural areas and specific groups such as youth, LGBTQ and aging individuals, and relative outcome data for persons with and without HIV/AIDS, TB and other diseases.

Criminal Justice Programming, Strengths, Needs, Strategies

Programming Strengths

- DMHA received the SAMHSA 2009 Offender Reentry Grant called Project CARE (Community Reentry and Reentry Enhancement). The grant is period will end Sept 30, 2012.

- DMHA currently utilizes state funding for one community based forensic diversion program and one forensic diversion program located in a locked facility.

- DMHA leads a DMHA/IDOC committee which also involves advocacy groups. The primary goal is to increase communication and collaboration.

- DMHA participates in the Indiana Juvenile Justice and Mental Health Collaboration Project Planning Grant. The primary goal is to increase public safety by facilitating collaboration among juvenile justice, mental health and substance use treatment systems across the state to increase access and improve outcomes.

- SAMHSA Access to Recovery grant has eligibility criteria aimed at criminal justice involved individuals.

- DMHA has a contract with IDOC to screen and educate incarcerated individuals on problem gambling. Referrals to treatment are made for individuals upon release.

Programming Gaps/Needs

- The SAMHSA 2009 Offender Reentry Grant called Project CARE (Community Reentry and Reentry Enhancement) grant period ends Sept 30, 2012.

- The contract for the forensic diversion program located in a locked facility ends June 30, 2012.

- Both forensic diversion programs focus on an adult population with substance use disorders and/or co-occurring disorders but not individuals who have only a mental health issue.

- Providers lack adequate information on evidence based practices and offender risk and needs assessments when working with individuals in the criminal justice system that are supervised by criminal justice agencies such as probation, parole, community corrections, and problem solving courts.

- Medicaid benefits are suspended when individuals are incarcerated.

- The 2006 MOU between FSSA-Division of Family Resource, the OMPP, and the IDOC to provide support services to incarcerated adult and juvenile offenders under the jurisdiction

of IDOC to identify individuals who would be eligible for government benefits including Medicaid prior to release is not happening.

- Individuals with substance use and mental health disorders are released from IDOC without Medicaid coverage. Those on medication are released with a 30 day supply and often have no means to refill the prescriptions. In many instances treatment services have not been arranged and community providers have wait lists which exceeds the 30 medication supply.

Criminal Justice Needs and Potential Strategies to Address Them

- Provide gap funding for a minimum of two years to the Offender Reentry- Project Care to assist the program in continuing until healthcare reform changes take place and provide health insurance coverage for participants.

- Work with the OMPP to remove the termination of Medicaid benefits for individuals who are incarcerated less than a year

- Work with FSSA Division of Family Resource, OMPP, and IDOC to ensure that individuals in IDOC start the Medicaid enrollment process prior to release and individuals are enrolled in Medicaid ASAP upon release.

- Individuals who are being released from incarceration should be included as a part of a Safety Net. These individuals may not have Medicaid when they are released or money for co-pays but are vulnerable to a return of mental health symptoms, use of substances and re-offending if they do not receive services. DMHA could work with IDOC to put a MOU in place to focus on Reentry.

- Incentivize programs like the Recovery Engagement Center which leverage existing community resources and can support and provide resources to individuals being released from prison. Allocate funding specific for forensic diversion programming and begin a "Request for Proposal" process for a community based forensic diversion program. Maximize funding by mandating that applicants must work with existing problem solving courts.

- Allocate funding for forensic diversion programming focused on individuals with a mental health issue.

- Allocate funding for community based forensic diversion programming focused on juveniles.

- Collaborate with the Indiana Judicial Center and the Indiana Department of Correction to facilitate training that addresses how to effectively work with individuals in the criminal justice system.

- Allocate funding to providers to be used specifically for individuals with substance use and mental health disorders in the criminal justice system. Funding can be used as a part of

safety net for individuals who are released and need to get Medicaid reestablished or for those that do not qualify for Medicaid but have no resources.

- DMHA can request that providers receive an endorsement which indicates competency when working with offender populations.

Suicide Prevention and Awareness

Prevention of suicide is a focus area in Indiana. Data from the National Suicide Prevention Lifeline show:

- Since its launch in January 2005, the National Suicide Prevention Lifeline has routed over 44,000 calls from individuals in Indiana who are in emotional distress or suicidal crisis
- Thanks to a partnership between the Department of Veterans Affairs (VA), the Substance Abuse and Mental Health Services Administration, and the National Suicide Prevention Lifeline, veterans in our state are able to seamlessly access care through the VA by dialing 1-800-273-TALK and pressing one. Since the launch of this partnership in July 2007, over 7,000 veterans in our state have been able to reach out for help.
- The Lifeline has an extensive backup system, which includes regional backup centers, as well as a national backup center, thereby ensuring that all calls are answered, even if the crisis centers in our state are beyond capacity.
- There are three lines that belong to the Kristin Brooks Hope Center that have been routed through the Lifeline system since March 2007, and currently these calls account for approximately 30% of Lifeline's total call volume. For Indiana, this equated to more than 3,500 calls in 2010.

Other data sources for Indiana have documented a high rate of suicide among adolescents in (Kids Count) and a high rate of suicide among National Guardsmen returning from Iraq and Afghanistan.

DMHA is making a concerted effort build an integrated system for suicide prevention and awareness. The State of Indiana has organized and successful suicide prevention programs and crisis line organizations scattered throughout the state. DMHA, in conjunction with the Indiana State Department of Health (ISDH) identified key staff to convene a planning committee and conduct a needs assessment to identify gaps in geographic areas or services.

Needs identified thus far by the committee include:

- increasing suicide prevention initiatives and efforts statewide focusing on youth and those that educate, mentor and have authority
- free or low cost training (online, in person or a combination) training course/resources for teachers and other school personnel
- training focused on African-American, Latino, Refugee, LGBTQ and juvenile delinquent populations

Following the needs assessment process, DMHA convened a state-wide suicide prevention advisory council to update the State's suicide plan. This workgroup includes DMHA staff, State Department of Health, law enforcement, mental health providers, advocacy groups, education and school personnel, faith-based groups, and an epidemiologist. The workgroup is focused on universal, selective, and indicated prevention goals. The state Department of Health is leading the evaluation process.

Racial and Ethnic and LGBTQ

The Indiana Division of Mental Health and Addiction (DMHA) historically focused on providing services to the underserved racial and ethnic minority populations. The targeted populations include (but are not limited to) African-Americans, Hispanics/Latinos, Asian-Americans, Native-Americans, Hawaiians or Pacific Islanders. Data related to Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) population is not collected in the State's database. National data states that the racial, ethnic minority and LGBTQ groups are at a higher risk for substance use disorder and mental illness. National data also suggests that these groups are underserved in receiving services in the mental health and addiction arena. Historically, minority groups are less likely to seek treatment than white Americans.

Despite Indiana's extensive data collection efforts (e.g., Indiana Youth Survey and Indiana College Substance Use Survey), LGBTQ adolescents and young adults remain largely unidentified rendering any surveillance on substance use and mental illness within that population non-existent. This lack of LGBTQ substance abuse data has been identified by State agency reports (Indiana Tobacco Use Disparities and Diversity (ITDD) Workgroup, 2003) and community organizations serving LGBTQ Youth. This is a gap that could be addressed through the Strategic Prevention Enhancement (SPE) grant.

DMHA has contracted for Cultural Competency training services and technical assistance since 1996. This training is made available to mental health and addiction providers throughout Indiana. The training addresses racial/ethnic/sexual orientation cultural issues. The 15 year life for this program and the regular changes to the curriculum are considered strengths of the system.

The most notable need related the racial, ethnic, LGBTQ populations is the collection of data on sexual orientation/identity and primary language spoken. DMHA data does verify that a disproportionate percentage of persons being served are from racial or ethnic minority groups. Indiana has a growing population of persons whose first language is Spanish which can pose a major barrier to receiving mental health and/or addiction treatment. DMHA will begin collecting client specific data on sexual orientation/identity and primary language spoken in state fiscal year 2013.

Persons with disabilities

The Division of Mental Health and Addiction has created a Bureau level position designed to address the special issues of those with either mental illness or a substance abuse that also have a physical disability. Critical Populations are defined as individuals or groups that have traditionally not been served or have been underserved in the Mental Health and Addiction arena. These individuals or groups are linked together by common factors such as poverty, disability, lack of or poor insurance, lack of accessibility to the mental health and addiction care system, mobility, etc. Populations that are disproportionately affected in the mental health and addiction system that the Division of Mental Health and Addiction (DHMA) target to provide services include, but are not limited to, African-American, Hispanic/Latino, Asian-Americans, Native-Americans, Hawaiian or Pacific Islanders, persons who are homeless, older adults, persons who are deaf or hearing impaired, persons with disabilities, migrants, and person with HIV/AIDS. DMHA continues to expand its ongoing network of relationships among consumers, family members, providers, community organizations, advocates, agencies, and concerned citizens locally and nationally in order to enhance participation in our programs, goals and objectives.

DMHA has provided staffing support for a Deaf and Hard of Hearing Task Force for four years. The work of this task force has been specific to identifying mental health and addiction needs for persons who are deaf or hard of hearing. DMHA has been assisted in providing this support by the state Deaf Services Office in the Division of Rehabilitation and Disabilities (DDRS). Persons who are deaf or hard of hearing, persons who use ASL exclusively, and persons who use other forms of communication have made up the majority of participants on the task force. The task force has developed a “white paper” with recommendations for system improvement and service expansion throughout the state. The recommendations have been shared with DMHA and DDRS leadership for future actions.

Persons with disabilities have been identified by DMHA as a special population. At this time we are not identifying any specific needs or gaps but may in future.

Disaster Preparedness and Response

DMHA is a full partner in the State's Homeland Security initiatives. The first responders in the State recognize that a behavioral health team is valuable during a natural or man-made disaster. DMHA has established behavioral health teams in each homeland security region of the State. These teams have established strong ties with local communities throughout the State. Relationships have been built with emergency response organizations, community leaders, schools, businesses, faith-based organizations, local health departments, State agencies, media and others that have proven vital when a natural disaster has occurred within our State. The continuance of these partnerships is essential for Indiana citizens to efficiently and effectively receive needed behavioral health services during a disaster situation.

The disaster preparedness and response activities supported by DMHA are considered strengths for the State. At this time, there are no identified needs or gaps related to these activities.

Behavioral Health Assessment and Plan

Planning Step 2

Identify the unmet service needs and critical gaps within the current system.

The process of utilizing the staff to develop narratives on the various populations and initiatives resulted in identification of many gaps and needs. These are listed below and are not a complete or exhaustive presentation of the system needs.

Identified Priority Areas for 2012-2013

Promotion of mental health and prevention of addiction

- Lack a statewide prevention and health promotion plan
- Need to identify gaps and capacity for mental health promotion and addiction prevention initiatives
- Updating statewide suicide prevention plan

Safe affordable home

- Lack of data on housing options
- Developing strategic plan to address housing issue

Recovery supports

- Need collection and coordination of data and information on non-traditional recovery supports
- Need statewide gap analysis of recovery priorities

Integration of Primary and Behavioral Health Care

- Lack of information and data
- Need to identify best practices for integration

Other Significant Needs/Gaps

Intravenous Drug Use (IVDU) Needs

- Baseline and ongoing Indiana specific data on IVDU,
- More Evidenced-Based Practices (EPBs) on outreach, intervention and treatment of persons with IVDU particularly in rural and other regionally specific groups,
- Outreach methods, including EBPs for outreach in rural areas and specific groups such as youth, GLBTQ individuals,
- Relative outcome data for persons with and without IVDU.

Women's Programming Gaps/Needs

- Additional training and technical support for evidence based gender specific treatment and interventions to be delivered to pregnant women and women with dependent children.

Criminal Justice Needs

- Current forensic diversion programs do not focus on individuals who have only a mental health issue.
- Providers need adequate information on evidence based practices and offender risk and needs assessments.
- Medicaid benefits are suspended when individuals are incarcerated.
- Individuals with substance use and mental health disorders are released from IDOC without Medicaid coverage.

HIV-AIDS-TB and other diseases

- Actual baseline and ongoing Indiana specific data on incidence in the general population,
- More Evidenced-Based Practices (EPBs) for outreach, intervention and treatment of persons with substance use disorders, including IVDU, particularly in rural and other regionally specific groups,
- Outreach methods, including EBPs for outreach in rural areas and specific groups such as youth, GLBTQ and aging individuals, and relative outcome data for persons with and without HIV/AIDS, TB and other diseases.

Suicide

- Increasing suicide prevention initiatives and efforts statewide focusing on youth and those that educate, mentor and have authority
- Free or low cost training course/resources for teachers and other school personnel
- Training focused on African-American, Latino, Refugee, LGBTQ and juvenile delinquent populations

Underserved racial and ethnic minority and LGBTQ

- Need the collection of data on sexual orientation/identity and primary language spoken.
- Persons whose first language is Spanish face a major barrier to receiving mental health and/or addiction treatment.

Planning Step 3: Prioritize State planning activities

Table 2 Plan Year 2012 – 2013

State Priorities	
1	Promote Mental Health and Prevent Addiction
2	Recovery Supports
3	Safe and Affordable Home in the Community for all Consumers
4	Integration of Primary and Behavioral Health
5	
6	
7	
8	
9	
10	
11	
12	

Planning Step 4: Develop objectives, strategies, and performance indicators

Table 3 Plan Year: 2012-2013

***Priority Area #:* 1 – Promote Mental Health and Prevent Addiction.**

Goal: To assure that communities in Indiana have sufficient support for provision of services for addiction prevention and mental health promotion.

Strategy (use as many lines as needed for each strategy):

1. Assess current data reported in the State Epidemiological Report and identify gaps in data for both mental health and addiction.
   - Define critical populations to be addressed in on-going state plan development and implementation
   - Identify key components to cultural competency approaches in regards to prevention efforts
2. Assess current efforts that support the integration of addiction prevention and mental health promotion and identify common approaches to programs, practices and policies where applicable.
3. Assess current level of coordination for delivery of mental health promotion and addiction prevention services by state agency.
4. Develop statewide strategic plans to address promotion and prevention services and needs in alignment with SAMHSA priority initiatives.
5. Complete updated statewide suicide prevention plan.
6. Support the Use of Evidence Based Programs, Practices and Policies for addiction and mental health promotion.

Performance Indicator:

1. Report that identifies gaps and capacity for mental health promotion and addiction prevention in Indiana.
2. Completed statewide suicide prevention plan.

Description of Collecting and Measuring Changes in Performance Indicator:

Currently alcohol, tobacco and other drug related data is reported through the SEOW Epidemiological Report. The SEOW committee will review data related to mental health promotion and identify priority areas for services. The data review will include the needs and resources available or needed to address the identified critical populations. Assessment will include a review of data sources currently available from state agencies/organizations and an identification of gaps.

Table 3 **Plan Year: 2012-2013**

Priority Area #: **2 – Recovery Supports**

Goal: To promote and develop State-wide recovery supports toward the goal of community integration for persons with mental illnesses and/or addictions.

Strategy (use as many lines as needed for each strategy):

1. Develop and implement a survey to garner consumer input regarding what recovery supports are most helpful for obtaining and maintaining a life in the community.
2. Using the existing annual Community Readiness Assessment of all state hospital consumers, gather and analyze data, by community, regarding the barriers to discharge from the state operated hospitals.
3. Execute a utilization review of recovery support services using data from the Access to Recovery and the Community Alternatives to Psychiatric Residential Treatment Facilities demonstrations. Follow with survey of currently served consumers to identify non-traditional recovery support services and activities consumers believe lead to positive outcomes.
4. Survey public behavioral health providers on what services they believe are included in a good and modern, recovery oriented continuum of care.
5. Analyze data from steps 1-4 to inform policy direction for program and funding priorities with focus on non-Medicaid or other agency funded supports.
6. Conduct gap analysis of desired recovery supports, with goal of statewide consistency and access of desired services.
7. Develop collaborative partnerships with other key state agencies for the purpose of facilitating interagency cooperation at the local level. This will include identifying common goals and needs, and developing strategies to address them.
8. Identify administrative changes (statute, administrative rule, contracting, etc.) necessary for success.

Performance Indicator:

1. Completion of data collection and analysis described in strategies #1-4.
2. Develop consensus on recovery support priorities.
3. Completed statewide gap analysis of identified priorities.
4. Number of key State agencies actively participating on the Mental Health and Addiction Planning and Advisory Council (MHAPAC) and actively participating in data analysis and prioritization of recovery supports.

Additional performance indicators will be developed over time as planning activities result in implementation of system change.

Description of Collecting and Measuring Changes in Performance Indicator:

1. The Community Readiness Assessment is completed annually for all adult consumers in state hospitals who are not on a criminal commitment. The assessment includes an estimated timeframe in which the consumer may meet discharge criteria, consumer treatment goals, type of residential placement needed upon discharge, and anticipated

services needed upon discharge. From this data, individuals estimated to be currently ready for discharge or ready within the next six months will be monitored to verify if they were actually discharged within that time-frame. The baseline will be established in 2012 and a target projection for 2013 will be developed from that baseline.

2. The DMHA Advisory Council is being reorganized in SFY 2012 to incorporate the Mental Health and Addiction Planning Councils. A significant objective of this reorganization is to empower the Council to actively participate in DMHA policy development and strategic planning as well as effectively engage key stakeholders, including other state agencies, in collaborative partnerships. This newly formed Planning and Advisory Council will foster and model partnering for local communities as well.

Table 3 **Plan Year: 2012-2013**

Priority Area #: **3 – Safe and Affordable Home in the Community for all Consumers**

Goal 1: Improve state-level understanding of housing options for consumers and of initiatives that lead to new housing options for consumers for the purpose of establishing a long-term strategic housing plan.

Strategy (use as many lines as needed for each strategy):

1. Obtain data regarding availability of housing options for consumers and consumer perceptions of their living environments
    a. DMHA will develop a comprehensive survey to determine current practices in the provision of housing and use the survey to assess current practices in the provision of housing that are being used by contracted mental health and addiction providers in order to further identify gaps in housing options for consumers.
    b. DMHA will add questions related to consumer's perception of his/her housing to the Mental Health Statistical Improvement Program Adult Consumer Survey (MHSIP) adult and Youth Services Survey for Families (YSSF) surveys.
2. Develop Task Force to review data and make recommendations for a housing strategic plan and to write an initial draft of the plan.
3. Plan to be provided to the Mental Health and Addiction Planning and Advisory Council (MHAPAC) for review, input, and endorsement.
4. DMHA administration will implement the plan and obtain on-going stakeholder involvement, including but not limited to, the legislative Mental Health and Addiction Commission and the MHAPAC.
5. Redefine certification and contract expectations to include Supportive Housing.

Performance Indicator:

1. MHAPAC will endorse the strategic plan and present it to DMHA administration for approval no later than June 30, 2013.

Description of Collecting and Measuring Changes in Performance Indicator:

Collection of data: Beginning in calendar year 2011, Indiana has added questions about the consumer or family's perception of their housing to the MHSIP and YSSF surveys. Calendar year 2011 surveys will be obtained from the Community Mental Health Center consumers. In calendar year 2012, the surveys will be expanded to include other addiction providers. The 2012 data will establish the baseline for performance indicators. In 2013, the surveys will be repeated to identify any positive or negative change in percentage of adults or families reporting positive perception of the living environment.

Task Force: The task force will be comprised of mental health and addiction organizations, State housing authority, and other State and community agencies (including property management groups) involved in housing initiatives, DMHA staff, consumers, and other advocacy groups.

Table 3 **Plan Year: 2012-2013**

Priority Area #: **4 – Integration of Primary and Behavioral Health**

Goal:

1. Establish a dedicated workgroup/committee to address this priority
2. Facilitate and promote the development and implementation of bi-directional integrated primary and behavioral health best practices across Indiana

Strategy (use as many lines as needed for each strategy):

1. Establish a dedicated workgroup/committee to explore and develop sustainable effective primary and behavioral health integration models. Partners include but are not limited to the Office of Medicaid Policy and Planning (OMPP), Indiana State Department of Health (ISDH), Indiana Primary Health Care Association (IPHCA), Indiana Council on Community Mental Health Centers (ICCMHC), three Substance Abuse and Mental Health Services Administration (SAMHSA) grant recipients (both the primary care and behavioral health care staff), HRSA, representation for consumers and their families.
2. Establish standards for consistency and quality in implementation, including potential rules / certifications.
3. Work with OMPP, ISDH, IPHCA, and ICCMHC to shape the development of health homes.
4. Promote the development and usage of Electronic Health Records and actively participate with the state health information exchange with all public behavioral health providers.

Performance Indicator:

1. Establish and appoint membership by April 1, 2012.
2. Determine best practices principles for bi-directional integrated primary and behavioral health practices which the state will endorse.

Description of Collecting and Measuring Changes in Performance Indicator:

Based on standards determined, create and implement survey to collect information about current integration activities being done at behavioral health care and primary health care sites. This survey would be done in the beginning to measure baseline and then annually.

Narrative Sections D through P

D. Activities That Support Individuals in Directing Services

The Division's Transformation to Recovery efforts are establishing access to availability of self directed care. The Division is assisting Community Mental Health Centers to develop and maintain supports that demonstrate consumer empowerment. Measures are being taken to educate consumers on recovery supports and help them self identify which of those supports are appropriate.

The Division has supported consumers through the promotion of Advanced Directives. Policy for State Operated Facilities instructs them to offer this to current and new consumers of services.

Community Mental Health Centers are actively involved in using Evidenced Based Practices as the basis for delivering consumer driven services. Many of these providers are embracing the transformation efforts and working to ensure the success of the consumers' abilities to direct their own care. A survey conducted in the spring of 2011 found that ninety percent (90%) of Community Mental Health Centers in Indiana self-report adoption of some form of Person-Centered Planning for their consumers.

Support of Consumer Operated Businesses and the modernization of the State's Medicaid Rehabilitation Option Plan are focused on setting the stage for consumers to have access to the most appropriate supports at the right time and in the right amount.

The state-wide consumer group, KEY Consumer Organization, is stepping up their efforts to assist the Division in outreach that will empower consumers to influence policy, direct recovery efforts and engage consumers in meaningful ways to plan for self directed care. The Division has supported KEY Consumer Organization since the late 1980's and continues to partner with them to promote and improve consumer involvement in their own care.

Through contracts with KEY Consumer and NAMI of Indiana the Division supports WRAP training, Peer to Peer training, and Peer Mentoring activities. A local Community Mental Health Center has been providing IMR for nearly a decade. Over 90% of all mental health providers report some form of illness management training for consumers and 63% report providing IMR with fidelity to the SAMHSA toolkit for some consumers. These initiatives are indicators of the commitment by the State to ensure consumers can participate as full partners in the evolution of care.

It can be best said that the Division is well on its way to incorporating self directed care as the norm rather than the exception. The Division recognizes the value of this and will continue to strive to achieve the highest standards of consumer driven public mental health and addiction services.

E. Data and Information Technology

List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:

- *Provider characteristics*
- *Client enrollment, demographics, and characteristics*
- *Admission, assessment, and discharge*
- *Services provided, including type, amount, and individual service provider*
- *Prescription drug utilization*

1. Data Assessment and Registration Mental Health and Addiction (DARMHA) is the primary community services database in Indiana. This database contains demographic, diagnostic, assessment, employment, living situation, criminal justice involvement, use of substances of abuse, admissions, discharges, services, etc. information about the clients. All data elements required for TEDS reporting and URS reporting are included in this database.
2. Avatar PM and CWS are the applications used to collect client information for persons admitted to the state hospitals. The PM application contains demographic, diagnosis, admission, discharge, legal status, type of commitment, etc. information about the clients. The CWS application contains multiple specialty assessments and the treatment plan and, as such, is part of the electronic health record.
3. Web Infrastructure for Treatment Services (WITS) is used for the SAMHSA ATR grant program. This application contains provider information, client information (demographics, characteristics, admissions, assessments, and discharges), services approved and provided, and amounts paid for services. The application also includes similar information related to providers of and persons receiving specific gambling services.
4. DMHA Certification and Licensure Database – collects information about provider address, key staff, type of certification, accreditation, locations. This application is being re-written and will include provider application forms for certification and licensure.

As applicable, for each of these systems, please answer the following:

- *For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?*

  None of the systems collect the NPI.

- *Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?*

  DARMHA, Avatar, and WITS each have unique provider identifiers. DARMHA and Avatar use DMHA assigned provider identifiers which are used for multiple purposes including budgeting, contracting, information technology, etc. WITS generates a provider identifier and also includes a contract number issued by the state for each provider for the purposes of claims and the state tax ID number for each provider.

- *Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?*

  DARMHA, Avatar, and WITS each contain a unique identifier for the clients receiving services. Each system has a master patient index process to assign the unique identifier which contains no protected health information. DARMHA and Avatar client identifiers can be matched to report unduplicated clients across the community and state hospital systems. Should the need arise, the WITS client identifiers could also be matched to DARMHA identifiers.

- *Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?*

  Client-level data in DARMHA and in WITS is in the form of encounter data which includes date of service, type of service and service quantity. DARMHA contains the identity of the rendering provider organization but not the specific staff person rendering the service. WITS contains both the rendering provider organization and the specific staff person rendering the service.

- *Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?*

  WITS does not collect diagnosis. DARMHA and Avatar do collect diagnosis codes. Currently, diagnosis may be entered using DSM-IV or ICD-9 codes. The state is working toward the required ICD-10 conversion by October 2013.

  CPT/HCPCS codes are collected in DARMHA for each service received by each client. This information is used to document services provided. Avatar uses the CPT/HCPCS codes, as appropriate, for billing purposes for patients receiving inpatient care. WITS collects a "procedure" code which has been developed by SAMHSA for the ATR grants.

As applicable, please answer the following:

- *Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?*

  DMHA data can be matched to Medicaid data with about 85% accuracy. Once the data is matched, provider identification occurs based on the DMHA provider. All provider and client data can be aggregated from the matched data set.

- *Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?*

As identified, routine reports from the matched data set can be produced. Currently, the primary use of this data is to identify percentage of persons in the DMHA database who at any time during the year were also Medicaid recipients. Although the DMHA database requires reporting the Medicaid identifier, some clients each year receive Medicaid benefits but are not reported as such in the DMHA database.

- *Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?*

  Monthly IT Forum meetings are held with technology staff from each division within the Indiana Family and Social Services Administration (FSSA). The forum discusses all aspects of information technology as well as planning activities related to emerging changes that will be necessary within the next few years. This group includes the technology staff working with:

  Medicaid and Food Stamps eligibility,
  Developmental Disabilities
  Vocational Rehabilitation
  Early childhood (0-3) services
  Aging, blind, deaf, and hard of hearing services
  Mental Health and Addiction
  Indiana Health Information Technology, Inc.
  Medicaid services, including waivers, managed care, and fee for service
  Indiana Office of Technology

- *Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?*

  Indiana received a Cooperative Agreement Program (CAP) grant and has created the Indiana Health Information Technology (IHIT) with the goal of establishing an effective network of health information exchange to support healthcare providers and enhance the quality of the state's healthcare system. Initially, IHIT is working with the state's five existing health information exchanges (HIE) and the two regional extension centers (REC) to expand collaborative efforts among these existing entities.

  The Secretary of FSSA sits on the Board of IHIT and the Director of DMHA is a member of the Board's Patient Advocacy Council. The Council provides specific input to the Board regarding the safety and privacy of patients and the security of protected health information as it relates to the development and implementation of the State of Indiana's health information exchange strategic and operating plans.

- *Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?*

FSSA has several major IT initiatives underway. Included in these initiatives are the ICD-10 conversion, MMIS/MITA, expansion of an enterprise-wide data warehouse, and implementation of an integrated case management system. Behavioral health is a full partner in all these initiatives. Additionally, several divisions are working to upgrade or significantly enhance their databases. Data interoperability and federal data standards are key considerations for each project.

Current efforts to assist providers with developing and using Electronic Health Records

Indiana contracts with private, non-profit entities to provide mental health and addiction services. All of the 25 Community Mental Health Centers have purchased and implemented an Electronic Health Record (EHR) or are in process of selecting an EHR. Organizations that provide only addiction services are not as aggressively pursuing EHRs and will need more assistance from the State as they embrace the new technologies. Decisions regarding the selection of and use of EHRs are solely the responsibility of the providers. The State can and will provide information about EHRs to providers upon request.

Collection and reporting data for specific services that are purchased with Block Grant funds.

Indiana currently collects extensive client-level data for all services provided by the contracted service providers of mental health and/or addiction services. However, there is no data related to which funds "purchased" a specific service. For example, a consumer may receive 10 hours of Addiction Counseling Service at a standard cost (value) of $580.32. The reimbursement of this cost may be from Medicaid, SAPT block grant dollars, private insurance, or provided with no reimbursement source. The same applies to expenditures. Unless the state moves to a fee-for-service reimbursement as opposed to the current contract allocation process, neither client-level nor aggregate reporting of services purchased is possible. At this time, there are no plans for immediate change to the way funds are allocated to contracted providers in Indiana. With the Medicaid expansion in 2014, the opportunity exists to revise the mental health and addiction funding methodology.

Reporting capacity for universal prevention and other non-service-based activities (e.g. education/training)

Currently, Indiana does not have a standardized way to collect the numbers and types of individuals impacted by universal prevention and other non-service-based activities. It is understood that collection and reporting of this data will be mandated by SAMHSA. Over the next two years, Indiana will work with entities with which we contract for prevention, training, education, and advocacy to develop capacity to collect this data.

Identify the barriers that your State would encounter when moving to an encounter/claims based approach to payment

Currently, Indiana applies an encounter/claims payment process for the limited number of clients receiving ATR services or specific gambling services. For the approximately 120,000 clients

receiving other community based services each year, we estimate that 90% would be eligible for Medicaid or expanded Medicaid in 2014. It is not known what services will be included in the expanded Medicaid program, and, therefore, not known what volume of consumers and claims would be the responsibility of the SMHA and SSA in a fee-for-service system.

If the State is required to pay providers on a fee-for-service basis, significant changes to the State's data, financial, and contractual infrastructures will be necessary. If the requirement includes knowing the funding source for each service/payment, the magnitude of the infrastructure changes expands exponentially. Infrastructure change of this magnitude will be very time consuming, human resource intensive and expensive. Any such changes would affect the state data system as well as the data systems run by each provider of services.

Indiana does have a voucher application for the ATR program. However, this application does not collect all the data necessary for TEDS or mental health client-level reporting. The application, developed on a shared source architecture, can be expanded to include more data. The scope of activities that would be required for this expansion, including the cost and length of time needed, has not been assessed. The primary community services database application can be modified to include a voucher process given sufficient time and money to expand that application.

Identify the specific technical assistance needs your State may have regarding data and information technology specifically in section 3.k.

Indiana has or can acquire the technical expertise to address any data or information technology changes. However, the State will need clear definitions of requirements from SAMHSA in a final format prior to beginning to program any change.

F. Quality Improvement Reporting

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

DMHA Continuous Quality Improvement Plan

Although DMHA has implemented numerous activities that monitor services and programs, a formal Continuous Quality Improvement (CQI) Plan is not yet available. A major CQI activity was created around performance measures and performance-based contracting. DMHA implemented performance based contracting beginning in state fiscal year 2007 to increase provider accountability, ensure that consumers had access to appropriated services, and to monitor consumer outcomes. Over the past six fiscal years, the performance measures have evolved and shifted emphasis from persons served and data submission to consumer outcomes. For state fiscal year 2012, providers are accountable for adult outcomes related to: employment, criminal justice involvement, substance usage, and overall improvement. For youth outcomes are related to: school performance, substance usage, risk behaviors, and overall improvement. For both adults and youth, providers are accountable for completion of required reassessments and average monthly number of persons served.

The performance-based contract sets aside a portion of the federal funds allocated to the providers. These funds may be earned throughout the fiscal year based on the provider's meeting the performance measure targets.

The State's CQI process should also track programmatic improvements. The focus thus far has been on consumer based outcomes versus specific programs unless required by an external body. As the State develops and implements the strategic plans described elsewhere in this document, new performance measures will be identified which include program improvements and may result in further evolution of consumer outcome measures.

A CQI plan will be developed over the next 12 months to address evolving priorities.

DMHA Quality Management Activities

The following activities and processes are currently in place to continuously monitor compliance with certification, licensure, and contract standards.

Managed Care Providers (MCPs) On-Site Reviews-

- Liaison staff conducts a minimum of 2 site visits per provider each fiscal year.
- The liaison and certification team will work together to determine what information needs to be gathered.
- Site visit reviews may be conducted using the following methods:
- Chart reviews, policy/procedure reviews, encounter/service data, visual observation, etc.
- Information from visits is summarized by liaison staff and reviewed to determine positive practices that can be shared with providers as whole, areas where technical assistance may be needed or areas that may require further review by certification staff for follow-up.

Toll-Free Consumer Service Line

- The toll free Consumer Service Line (CSL) operates 8:30 a.m. to 5:00 p.m. during normal business hours. Consumer Service Line staff (vendor) accept complaints, concerns, or compliments related to MCPs and SOFs which are assessed for seriousness/urgency.

Quality Assurance Reviews

Indiana FSSA/Division of Mental Health and Addiction (DMHA) contracted with HP to conduct quality assurance reviews. These reviews began in April 2010. DMHA selects the certified provider agencies that are to be reviewed, and HP works with DMHA to set the review schedule. DMHA notifies the agency to be reviewed about two weeks prior to the review. The two- to three-person HP review team conducts the scheduled on-site review and records findings on the electronic tools developed by DMHA and HP.

Types of Quality Assurance Reviews

- Managed Care Providers (MCP) Review
- Private Mental Health Institutions (PIP) Review
- Transitional Residential Services (TRS) Review
- Addiction Services Only (ASO) Review
- Opioid Treatment Provider Review

Quality Assurance Calls

- QM calls to providers regarding required services to consumers.

State Operated Facility (SOF) / Gatekeeping

- **Annual Community Readiness Assessment**
  - Conducted jointly by gatekeepers and SOF staff annually, assessments are completed capturing information recommended by advisory work groups consisting of community providers, state hospital staff, and representatives of Key and NAMI.
  - Assessments are conducted with direct consumer participation and analyzed by DMHA liaison and management staff by population, by SOF, and for program improvement to help meet consumer recovery goals.

- **Monitoring of Gatekeeper Rule**
  - Currently DMHA is developing measures to monitor gatekeeper compliance related

to face-to-face requirements defined under 440 IAC5-1-3.5. Direct contact between gatekeeper and consumer assures continuity of care and on-going planning for the consumer's integration into the community.
    - Items to be monitored include timeliness of visits, thoroughness of documentation, and patient participation in recovery goal development.

- **SOF Bed Allocation and Utilization**
    - There is a set number of approved state operated facility beds allocated per provider by the State for the inpatient care of various adult populations in State Operated Facilities. Each provider assures the State that at no time will they use more than the allocated number of beds unless they have received authorization from the DMHA that the Contractor has entered into agreement to utilize an unused SOF bed of another Community Mental Health Center (CMHC).

    - A monthly allocation report is produced monthly for the month prior identifying the number of patients each provider has placed in an SOF. The report(s) identify any over/under allocations per provider to be used by the Office of Finance for fiscal decision making and contract monitoring. DMHA is currently developing measures to monitor individual bed utilization by provider.

Children's Block Grant Activities
- Choices Technical Assistance Center
    - Annual system of care conference
    - Coaching and consultation with DMHA currently funded system of care grantees
- System of Care community grants
    - Local coordinator hired
    - Outcome measures and sustainability plan developed
- Family Involvement Grants
    - Technical assistance to family support groups
    - Financial oversight through contracted vendor

Substance Abuse Prevention and Treatment (SAPT) Block Grant
- Annual selection of ***12-13*** MCP providers, to review addiction programming compliance with SAPT Block Grant requirements:
    - Capacity Monitoring Procedures
    - Referral for Ancillary Services
    - TB Services
    - Referral Agreements
    - Continuing Education
    - Services for Women During Pregnancy/Women with Dependent Children

Opioid Addiction Treatment Quality Management Activities
- Quality management activities include: a biennial report to the Governor, Legislative Council and the State Department of Health, education and training activities for OTP staff and

others, annual facility and programmatic audits of the regulated OTPs per 440 IAC 10-3 and 4, and response to inquiries and complaints from the public and/or OTP patients and their families.

- Annual OTP facility and programmatic audits are required by IC 12-23-18-5 and hold OTPs accountable for adherence to both 440 IAC 10-3, Certification of Opioid Treatment Facilities, and 440 AIC 10-4, Specific Approval of Opioid Treatment Programs. These standards went into effect January 26, 2010.
- DMHA conducts ***annual*** on-site inspection/reviews of ***every*** Indiana opioid treatment providers (OTP's) to determine compliance with 440 IAC 10-3, the OTP certification rule's requirements and standards.
- DMHA contracts with HP Enterprises to conduct audits of OTP service provision based on programmatic standards which cover program administration and service provision.

Gambling

- Toll-Free Hotline
    - Quarterly Reports
    - Random quality management calls by DMHA staff

Special Programs & Grants

- **CA-PRTF**
    - Provider documentation, services, access, and other clinical documentation is reviewed by the State team at least once per year per site – improvement plans are required for significant findings
    - Approval of all treatment plans for every participant
    - Wraparound Facilitator Training prior to approval as WF provider under grant
    - National and State evaluation includes WFI, YSS and YSS-F
    - System of Care quarterly meetings with all Wraparound Facilitators
    - CANS SuperUser training for all Wraparound Facilitators and Access Site

- **Access to Recovery (ATR)**
    - Ongoing monitoring by Project Director and two Regional Coordinators at the State
    - Client satisfaction survey - All RC agencies provide all ATR clients the opportunity to report a simple survey of how satisfied they are with each provider from which they have received services.
    - Project Evaluation by SAMHSA (typically completed once per grant cycle)
    - Quarterly RC file reviews - at least once every quarter Indiana ATR staff visit each RC agency and review a selection of files for policy and procedures of the INATR program.

Process for Responding to Critical Incidents, Complaints and Grievances

Contract Provider Complaint/Incident Response Guidelines

- Receive CSL/Complaint/Incident/Sentinel Report
    - Make determination if CSL/Complaint/Incident/Sentinel Report requires a referral to more appropriate entity

    - Make determination if the CSL/Complaint/Incident/Sentinel Report can be addressed with an internal fact-finding review or requires a more in-depth review by a contracted vendor (i.e. HP)
- If an internal fact-finding review is determined, Provider and Community Relations Liaison to formulate an action plan and conduct fact-finding (works with Certification as needed)
    - There may be reluctance to submit to DMHA fact-finding by the effected provider. Fact-finding should be framed as a request for more information by DMHA as the Certification/Contracting entity and is intended to garner information without an admission of liability/causative action by the provider related to the specific issue and any corrective actions taken/lessons learned.
- Case, action taken, and responses are staffed with the supervisor as needed
    - Additional case follow up as recommended by supervisor is completed
    - There may be reluctance to submit to additional DMHA fact-finding by the effected provider. Additional fact-finding should be framed as a request for more information by DMHA as the Certification/Contracting entity as information previously submitted (CSL response, Incident Report form, etc) did not provide DMHA with a complete understanding of the specific issue and any corrective actions taken.
- If it is deemed that there has been no violation of licensure standards, certification standards and/or contractual requirements, then DMHA's response to the provider and complainant is finalized
- A copy of the CSL/Complaint/Incident/Sentinel Report and all correspondence is filed
- If it is deemed that the CSL/Complaint/Incident/Sentinel Report has not been resolved with the internal fact-finding a more in-depth review by a contracted vendor (i.e. HP) should be staffed with Assistant Deputy Licensure, Certification and Contract Compliance
    - Case, action taken, and responses are staffed with the vendor
    - The vendor formulates an action plan and conducts an on-site review
    - A determination of licensure standards, certification standards and/or contractual requirement violations is made
    - A report summarizing review findings and recommendations is drafted by the vendor and approved by DMHA staff
    - DMHA constructs a cover letter to accompany the findings report which outlines the expectations of the provider (e.g. plan of correction, monetary sanctions, change in certification/licensure/contract status, etc)
    - DMHA sends the report and/or meets with the provider
    - DMHA staff monitors provider compliance with recommendations/expectations
    - The vendor may conduct additional on-site reviews to ensure compliance with recommendations/expectations
    - A copy of the complaint/incident and all correspondence is filed

<u>Non-Contract Provider Complaint/Incident Response Guidelines</u>

- Receive complaint/incident report from entity other than Consumer Service Line (CSL)
    - All complaints received through the CSL will follow CSL operating procedures

- Staff with the complaint/incident workgroup, composed of representatives from Provider and Community Relations, Certification, OGC and other DMHA staff as deemed appropriate
    - Make determination if complaint/incident requires a referral to more appropriate entity
    - Make determination if the complaint/incident can be addressed with an internal fact-finding review or requires a more in-depth review by a contracted vendor (i.e. HP)
- If an internal fact-finding review is determined, Provider and Community Relations Consultant works with Certification to formulate an action plan, citations of authority to review and conduct fact-finding
- Case, action taken, and responses are staffed with the workgroup
- Additional case follow up as recommended by the workgroup is completed
- If an internal fact-finding review is determined, Provider and Community Relations Liaison to formulate an action plan and conduct fact-finding (works with Certification as needed)
    - There may be reluctance to submit to DMHA fact-finding by the effected provider. Fact-finding should be framed as a request for more information by DMHA as the Certification/Licensure entity and is intended to garner information without an admission of liability/causative action by the provider related to the specific issue and any corrective actions taken/lessons learned.
- Case, action taken, and responses are staffed with the supervisor as needed
    - Additional case follow up as recommended by supervisor is completed
    - There may be reluctance to submit to additional DMHA fact-finding by the effected provider. Additional fact-finding should be framed as a request for more information by DMHA as the Certification/Licensure entity as information previously submitted (CSL response, Incident Report form, etc) did not provide DMHA with a complete understanding of the specific issue and any corrective actions taken.
- If it is deemed that there has been no violation of licensure standards and/pr certification standards then DMHA's response to the provider and complainant are approved by the workgroup and sent
- A copy of the complaint/incident and all correspondence is filed
- If it is deemed that the complaint/incident has not been resolved with the internal fact-finding a more in-depth review by a contracted vendor (i.e. HP) will be requested
- Case, action taken, and responses are staffed with the vendor
- The vendor formulates an action plan and conducts an on-site review
- A report summarizing review findings and recommendations is drafted by the vendor and approved by DMHA staff
- DMHA constructs a cover letter to accompany the findings report which outlines the expectations of the provider (e.g. plan of correction, monetary sanctions, change in certification/licensure/contract status, etc)
- DMHA sends the report and/or meets with the provider
- DMHA staff monitors provider compliance with recommendations/expectations

- The vendor may conduct additional on-site reviews to ensure compliance with recommendations/expectations
- A copy of the complaint/incident and all correspondence is filed

G. Consultation with Tribes

The total American Indiana/Alaskan Native population in Indiana is 0.3%. The largest increase among Indiana's population has been among Hispanic/Latinos that make up 6% of the population. The fastest growing minority are Asians at 1.6% of the population. Additionally, Indiana has the third largest population of Amish in the United States with 19 settlements representing a population of more than 35,000.

A portion of the 0.3% American Indian/Alaskan Native population is made up of the Miami Nation of Indiana. The Miami's are not a federally recognized tribe. Legislation was introduced in the 2011 session of the Indiana General Assembly to confer state recognition on the Miami Nation but the bill died in committee without receiving a hearing.

The Pokagon Band of Potawatomi Indians is a federally recognized tribe of 3,150 members. The land held by the tribe in federal trust is all located in Michigan and the tribal government is located in Dowagiac, Michigan. The tribe considers the Pokagon Homeland to be made up of four counties in southwest Michigan and six counties (LaPorte, St. Joseph, Elkhart, Starke, Marshall and Kosciusko) in northwest Indiana.

The Pokagon own and operate the Four Winds Casino Resort in New Buffalo, Michigan and the new Four Winds Hartford which is scheduled to open in the late summer of 2011.

The Pokagon Band Behavioral Health Services is licensed by the State of Michigan to provide outpatient counseling for mental health and substance abuse.

Due to the tribal government and services being based in Michigan the Indiana Division of Mental Health and Addiction (DMHA) has not had a relationship with the Pokagon Band of Potawatomi Indians.

However, DMHA is in the process of identifying the proper contact in the Pokagon tribal government to ascertain the willingness of the tribe to consult in the ongoing development of the Block Grant plan. Additionally, this could include invitations to participate as a member of the State Epidemiological Outcomes Workgroup (SEOW) or the Mental Health and Addiction Planning and Advisory Council (MHAPAC).

H. Service Management Strategies

A first step towards ensuring that the right scope, amount and duration of services are available to clients in Indiana has been implemented by the State Medicaid Agency (SMA) for persons receiving Medicaid benefits. That process involves a partnership between the SMA and the SMHA/SSA. The determination of eligibility for Medicaid Rehabilitation Option (MRO) services is based on diagnosis plus assessed level of need which are data collected by the SMHA/SSA. Actual assignment of service packages based on these two data is the responsibility of the SMA.

The Indiana SMHA/SSA has not developed utilization management strategies or processes for the non-Medicaid recipients who receive public mental health and/or addiction services. Over the next year, Indiana will be analyzing data from the SMA to assess the utilization of MRO service packages and the outcomes being experienced by Medicaid recipients due to the changes in MRO eligibility.

As stated elsewhere in this application, Indiana currently provides funds to contracted private, not-for-profit agencies for delivery of mental health and addiction services. These funds are not tracked by source and do not purchase specific services for specific clients. Therefore, Indiana will begin internal discussions regarding what benchmarks will decide over- or under-utilization of services funded by all funding sources. The results of the MRO analysis will be a key component of further utilization management activities.

Development of specific service management plans and strategies will be implemented. At this time, a target date to begin planning for utilization management processes is July 2012.

I. State Dashboard

Table 10 Plan Year 2012-2013

Priority Area	Performance Indicator
#1 - Promote mental health and prevent addiction	Report completed that identifies gaps and capacity for mental health promotion and addiction prevention in Indiana by June 30, 2013
#1 - Promote mental health and prevent addiction	Completed statewide suicide prevention plan by December 31, 2011
#2 - Recovery Supports	Completion of data collection and analysis described in strategies by March 31, 2012
#2 - Recovery Supports	Development and consensus on recovery support priorities by the end of June 30, 2012
#2 - Recovery Supports	Completed statewide gap analysis of identified priorities by November 30, 2012
#2 - Recovery Supports	Number of key State agencies actively participating on the Mental Health and Addiction Planning and Advisory Council (MHAPAC) and actively participating in data analysis and prioritization of recovery supports (baseline to be determined by June 30, 2012)
#3 – Safe and Affordable Home in the Community for all Consumers	MHAPAC will endorse the strategic plan and present it to DMHA administration for approval no later than June 30, 2013
#4 - Integration of Primary and Behavioral Health	Establish and appoint membership for the integration workgroup by April 1, 2012
#4 - Integration of Primary and Behavioral Health	Determine best practices principles for bi-directional integrated primary and behavioral health practices which the State will endorse by June 30, 2013

The State-specific performance indicators are related to the strategies developed under the prioritized State planning activities. These performance indicators tend to be measures of system improvement activities grounded in the integration of traditional mental health and addiction activities. They are not specific to either mental health or substance abuse or to specific services, populations, or programs. In 2012-2013, the State intends to devote significant resources to

planning activities that will re-position the State for anticipated systemic changes in 2014. Therefore, the 2012-2013 block grant application is a "plan to plan" through data collection and analysis with the involvement of stakeholders across the State.

#1 - Promote mental health and prevent addiction:

a. Indiana has been engaged in prevention efforts related to addiction for many years with a primary emphasis on youth. Mental health promotion activities have been minimal. Significant work will be completed to develop a fuller understanding of the State's needs for mental health promotion and addiction prevention for all populations. Once needs are identified, a gap analysis will be completed and workgroup planning efforts will result in one or more reports of the findings with strategic initiatives to address the needs and gaps.
b. Indiana has had a suicide prevention plan for the past several years which has become outdated. The plan is currently undergoing extensive review through a partnership with the Indiana State Department of Health and with the involvement of stakeholders from across the State. Following this review process, the plan will be rewritten.

#2 - Recovery Supports:

a. An essential element for access to and maintenance of "a life in the community" is the availability of appropriate and accessible recovery supports. DMHA recognizes inequalities across the state related to these supports. However the amount of inequality has not previously been quantified. The goal and strategies for this priority area are directed to completing a full needs assessment, developing consensus on the most important supports that should be available to all consumers, prioritization of these supports, and completion of a gap analysis related specifically to the prioritized recovery supports. This rationale applies to the first three (3) Recovery Support performance indicators.
b. A mental health block grant requirement which has been carried over into this integrated block grant is that certain State agencies must be represented on the planning and advisory council. Historically, full engagement of these partners on the council has been difficult. Recovery supports will require close collaboration with other state agencies that can assist with facilitation of interagency cooperation at the local level. The mechanism that will be used to develop the necessary partnerships and collaboration will be the Mental Health and Addiction Planning and Advisory Council. The fourth Recovery Support performance indicator will monitor progress toward sustained engagement of other State agencies.

#3 - Safe and Affordable Home in the Community for all Consumers:

Indiana is in the midst of a major culture shift related to where consumers with mental health or addiction issues live. This culture shift will require adoption of shorter lengths of stay for persons admitted to the state hospitals and migration from congregate living environments in the community to more integrated and independent housing options. Some people believe that every person with a behavioral health disorder should have significant choice in deciding where to live. Others believe that consumer safety requires close supervision and oversight which is best accomplished through congregate housing. The strategies for the housing priority area are intended to create the vehicle (a housing strategic plan) through which this dichotomy is resolved and the culture shift is realized.

#4 - Integration of Primary and Behavioral Health:

Primary and behavioral health integration initiatives have taken multiple forms in Indiana. However, it is difficult to determine what works well and what does not due to the lack of objective data. The primary goal for this priority area is the development of standards and principles that support consistency and quality for bi-directional integration of primary and behavioral health practices. In order to accomplish this, a workgroup will be convened to review the models of integration that are currently being implemented nationally and to recommend specific practices for the State.

J. Suicide Prevention

The Indiana Division of Mental Health and Addiction (DMHA) is making a concerted effort build an integrated system addressing suicide prevention and awareness. The State of Indiana has a few organized and successful suicide prevention programs and crisis line organizations scattered throughout the state. While few of these efforts have been successful, it was not clear to the State if there were areas missing suicide prevention or intervention services. Therefore, DMHA, in conjunction with the Indiana State Department of Health (ISDH), identified key staff to convene a planning committee and conduct a review to determine if there were any gaps in geographic areas or services. It was determined to collect data in a four prong approach: 1.) An electronic survey of providers and key stakeholders, 2.) A review of current ISDH statistics regarding suicide, 3.) A key stakeholder summit and, 4.) Additional research.

Objectives

- To provide a current snapshot of ongoing suicide prevention and education efforts.
- To define categories of need for prevention and education efforts.
- To ensure high risk suicide populations have prevention and interventions services.
- To ensure there is crisis line coverage available statewide.
- To develop a State Suicide Prevention Plan.

In early 2010, DMHA conducted a State of Suicide Survey. The goal of the survey was to create a snapshot of current prevention and intervention services in place within the state. The survey represented a large cross section of affiliations. These included K-12 schools, higher education, state offices, clergy, medical, mental health/addiction, military, law enforcement/correctional, family-focused services, advocacy organizations, and suicide-focused programs. The two largest groups responding were K-12 education and organizations associated with mental health/ addiction. The survey was sent to 1,428 persons and forwarded to at least 365 more respondents. The estimated response rate was 42% with 751 responding (382 full and 369 incomplete responses).

The survey confirmed that the counties with the highest coverage of services were those located in central Indiana that have the largest populated cities in the state. Conversely, the counties with the lowest coverage in services were located in the southern portion of the state characterized as more rural, less-population dense cities/communities. Current data from the Indiana State Department of Health reveals that 48% of Indiana's 92 counties exceed the statewide suicide rate, which has increased the past three years. Many of these high incidence counties are in areas of the state not served by current suicide prevention activities. There are numerous gaps in service in the rural areas of Southern Indiana. There is a critical gap in having an established Lifeline Suicide Hotline provider. The lack of representation results in calls being forwarded to Kentucky, Ohio or northern/central Indiana providers; thereby limiting the knowledge of local community resources for referrals to callers. Nearly half (44%) of survey respondents indicated that they do not refer individuals to a lifeline or crisis line. In addition, 86.3% of the 44 counties with the highest suicide rates have one or more shortages of services. Several of these areas are underserved by not only mental health service providers, but also medical and other professional

health providers. Complicating matters, the socioeconomic demographics of the indicated critical areas include workforce shortages, uninsured residents, fewer referral options and lack of training/skills among the very few health and community providers.

Upon completion of the survey, the Division of Mental Health and Addiction (DMHA), in conjunction with the Indiana State Department of Health (ISDH) identified key stakeholders to convene a Suicide Prevention Summit to review and clarify the survey results. DMHA and ISDH co-hosted the summit to discuss the gaps in services and future needs for suicide prevention activities. The Executive Summary of the Summit included:

> ***Overall Observations:*** Some overarching themes emerged from the observations made by the groups. The fact that many programs are already in place was recognized. However, better coordination of efforts and the reduction of silo issues need to be put into place. Stigma still exists around suicide and mental health, creating barriers to universal receptivity of prevention and intervention efforts; therefore, an awareness campaign is needed. Rural areas are not afforded equal access to treatment or suicide prevention/intervention efforts, demonstrating inequality of health care and health information. Finally some populations may be ignored in these efforts, especially the elderly.
>
> ***Prevention Concerns:*** In this area, groups were advised to identify concerns without providing solutions. Several concerns centered on certain population groups. One named high risk group was middle-aged white males, as demonstrated in the ISDH presentation on prevalence of suicide. Other groups appeared to be overlooked or marginalized in terms of receiving prevention or intervention services. The small groups recognized the need for cultural sensitivity and specialized approaches for certain groups such as those with diagnosed disabilities, those suffering from various chronic diseases and their care-givers, first responders to suicide events, and veterans. Therefore, efforts need to be provided across all systems and populations. It was recognized that prevention curricula currently being used across the state is not uniform in content or approach and lacked evidence-based endorsement in most cases. Funding for prevention delivered by community mental health centers is not currently available through the state, creating a barrier to their providing prevention services or training.
>
> ***Intervention Concerns:*** Training and funding for intervention services were viewed as concerns because the result is a lack of knowledge on the part of primary care physicians, emergency nurses, jail and detention center personnel, and school personnel among others who could be key interventionists. The issue of training bilingual interventionists to provide access to all populations was raised. A lack of linked hotlines creates information gaps and delays in response. Insufficient access to services and systems of care were perceived as not communicating adequately to support individuals at high risk. Information gaps such as coordinated statistical data, personal history data, and attempt data create systems gaps that allow at-risk individuals to become hidden. The relationships between suicide, gambling, and addiction are not highlighted sufficiently. Barriers to dissemination of information or skills training were identified especially among some religious groups. Further, obtaining buy-in from decision-makers that a

strong need for suicide training exists is difficult, requiring well-planned and customized approaches. Finally, other forgotten groups in the aftermath of suicide attempt or completion are family members and those belonging to other social networks of the suicidal individual.

More Data: The small groups saw a need for more data to understand the true matrix of services that exist in each county of Indiana. A centralized speakers' bureau made up of individuals with strong credentials on training topics was proposed as an information gap. More research on the various evidence-based practice registries and the rigor of their evaluations was identified as a need. A data-gathering system that would bring coroner reporting to a consistent level and unified self-harm data collection would provide more accuracy among county reports. More knowledge of risk factors and co-occurring disorders and their relationships to suicide was requested.

Strategy Development: The concerns and strategies to address those concerns provide an excellent foundation for prioritization, discussion, and action. To incorporate the strategies to any degree will require coordination and consensus-building among key stakeholders. DMHA is providing a vehicle for further study through the formation and convening of an advisory group.

Many of the recommendations from the State of Suicide Survey and Summit include increasing suicide prevention initiatives and efforts statewide focusing on youth and those that educate, mentor and have authority. There was a critical need for free/low cost training (online, in person or a combination of) course/resources for teachers, as well as other personnel. There is a need for the training to focus on minority (AA, Latino, Refugee, GLBTQ, and juvenile delinquents) populations. There is also a desperate need for a hotline/crisis line in Indiana communities that lack local resources. In addition, Indiana needs to create or build upon local suicide prevention councils, which include key community stakeholders that can provide support and training. To that end, DMHA and ISDH have assembled and co-chaired a Suicide Prevention Advisory Committee. The group is comprised of representatives from ten organizations, including membership from other state agencies such as ISDH and the Indiana Department of Education, in addition to community organizations whose focus is on providing mental health services and suicide prevention efforts. The Committee is charged with developing a new state suicide prevention plan to better meet the needs of Indiana residents and close existing service gaps. The plan will guide DMHA and ISDH dedication to increasing suicide prevention awareness, education and resources throughout Indiana as well as monitor the progress of the state in achieving its goals and objectives.

The Suicide Prevention Advisory Committee has convened four times since inception. They have reviewed and analyzed several state suicide prevention plans as well as national strategies to discuss and select features that could be used in Indiana's Suicide Prevention Plan. A general plan framework was developed. Four subcommittees have been formed and are currently meeting and working on an outline for their assigned suicide risk group. The Suicide Prevention Advisory Committee will meet again this fall where the subcommittees will bring their work to be vetted and discussed. The State Suicide Prevention Plan will begin to evolve from this meeting forward.

K. Technical Assistance Needs

Technical assistance needs for Indiana include:

1. Assistance for the development of the State Dashboard project will be needed. We anticipate having technical assistance from the mental health DIG and the substance abuse DASIS projects or, possibly, from the Center for Behavioral Health Statistics and Quality (CBHSQ). Specific information that will be needed includes (1) any expectation that state dashboards are similar from state to state and (2) design and input process for the SAMHSA website dashboard. We are currently looking at other States' website to determine how data is being presented across the country and at dashboards within our state from various entities including the state government portal.

2. We anticipate the need for technical assistance in facilitation of the planned task force for the housing strategic plan development. The task force will be comprised of stakeholders from varying perspectives. Indiana has identified the need for a facilitator who brings knowledge of successes in other states. Someone who is well versed in safe, affordable, and independent housing for persons with disabilities and committed to these housing programs would be a tremendous asset in helping to ensure that the task force members work together toward a common goal within the time allowed. DMHA is considering contacting the TAC in Boston for technical assistance.

3. Technical assistance needs for Mental Health Promotion and Addiction Prevention will emerge from the development of a new prevention strategic plan. Indiana has applied for the Strategic Prevention Enhancement (SPE) grant to assist with the development of the plan. As technical assistance needs are identified through the development of the plan DMHA will follow the normal procedures for requesting TA through the Central Regional Expert Team (RET) of the CAPT or through the Strategic Prevention Framework and Support (SPFAS).

4. For mental health promotion, we will need Technical assistance around coalition building and development. This would support the formation of additional local suicide coalitions around the state and strengthen those that currently exist.

5. Promoting and facilitating implementation of integration of primary and behavioral health in Indiana is critical. Technical assistance may be needed in identifying and facilitation of implementing best and promising practice models related to bi-directional primary and behavioral health integration and in defining and implementing core outcome measures to assess effectiveness of models/practices implemented. Included in this, DMHA is committed to partnering with OMPP and other stakeholders noted to assist with the shaping and developing of health homes. DMHA has been involved with a cross agency stakeholder group discussing and trying to address these needs. There are a wide range of practices calling themselves integrated models. More information and guidance is needed to determine best/promising practices and how to measure effectiveness. HRSA has offered some guidance which has been helpful but more extensive assistance is needed.

6. Indiana DMHA is committed to continuing and expanding the use of consumers as formal peer supports. Technical assistance, for both the State and the local providers of services, could assist our state in more rapid development of these new endeavors.

   Integration of Certified Recovery Specialists into routine behavioral health services will be an area of concentration over the next two years. Indiana has trained and certified 124 consumers of services as Certified Recovery Specialists. This program, funded by the block grant, is intended to improve work force development as the state continues to develop a good and modern recovery-oriented system of care.

   Currently less than 30% of those consumers trained and certified are employed in the public mental health system as formal peer supports. DMHA is striving to have all community mental health centers employ Certified Recovery Specialist as agents of change.

   Specifically, Indiana would benefit from models from other states that have been successful in widespread integration of formal peer supports in those states programs. Indiana is also looking for models for consumer organizations to become the broker of these services.

7. As the state continues movement towards full integration of mental health and addiction programs and practices, technical assistance may be needed to identify best or promising practices that produce good outcomes. The state has encouraged the development of Integrated Dual Diagnosis Treatment teams which approaches integrated treatment through use of teams similar to the Assertive Community Treatment process. The state has also worked with Dr. Mark McGovern (Dartmouth Psychiatric Research Center) on a project to implement Integrated Treatment of Co-Occurring Disorders using the DDCAT as a measure to assess addiction treatment services capacity for co-occurring disorders. Neither of these initiatives has been embedded in routine practice across the state. DMHA may need assistance in driving a culture, policy, and organizational change to reduce/eliminate siloed care and promote integrated care.

8. DMHA will begin the process of developing a strategic plan for children and adolescent services with the participation of all state agencies involved with children as well as some community agencies and family/youth members. We anticipate additional technical assistance needs to emerge. The state has identified gaps with regard to accessing adolescent substance use services and the lack of available promising practices for this population in our state. Someone who is able to assist with building provider capacity around adolescent substance use services as well as other gaps that are identified through our strategic planning process would be very helpful.

9. Indiana will be receiving Technical assistance on wraparound implementation from Innovations Institute through University of Maryland, Division of Child and Adolescent Psychiatry. Innovations Institute will assist Indiana with workforce development, system level implementation support and evaluation activities that facilitate continuous quality improvement. Through this TA, Indiana will develop an Advanced Wraparound Practitioner

Coaches Certification Program in order to create and sustain a high-fidelity and quality wraparound practice. This initiative is funded 100% through Centers for Medicare and Medicaid Services. Additional technical assistance will not be needed.

L. Involvement of Individuals and Families

The Indiana Division of Mental Health and Addiction has a long history of promoting the inclusion of individual consumers and families in our planning efforts. Under Public Law 99-660, the predecessor of the block grants, the Division included individuals and families in planning efforts. Recovery language has been included in the Divisions plans as early as 1991, as published in "The Indiana Response to Public Law 99-660; 1989-1991". An example of the Division's support is of KEY Consumer Organization, our state-wide consumer business, providing funding and support before Block Grant funds became available in the early 90's. The Division continues to support KEY Consumer Organization as an important support for individuals and families.

The Division actively leads and supports activities to increase the level of involvement and effectiveness of consumer and family networks. Funding opportunities and technical assistance to sustain community involvement necessary for enhanced community development are a primary focus. The Division has regular meetings in the community with: consumers, formal consumer groups, and family organizations. These meetings center on the improvement of the mental health system through consumer and family involvement in policy development and implementation.

All of the meetings listed below, include opportunities for individual and families to participate in monitoring the state mental health services. These are also opportunities to formally submit plans to address community needs.

Consumers and families participate in regularly scheduled council and committee meetings, such as; Mental Health Advisory Council, a State-legislated council; Community Mental Health Services Block Grant Planning Council; Addictions Planning Council; Indiana Suicide Advisory Committee; Indiana All Hazards Advisory Committee; Systems of Care; Community Alternatives to Psychiatric Residential Treatment Facilities; Family Initiatives Grants; Access to Recovery; Indiana Consumer Council and the Deaf and Hard of Hearing Task Force.

The Division supports a wide variety of community organizations by providing staff that act as liaisons and provides technical assistance for planning and program development. The Division currently supports: Family Action Network; Federation of Families; Indiana Council on Problem Gambling; Indiana Addictions Issues Coalition; National Alliance on Mental Illness; Mental Health America and KEY Consumer Organization. Within each organization are projects that are supported by the Division.

Indiana is currently funding three new programs for support of individuals. These Consumer Operated Businesses are fully funded by the Division. These are completely planned, operated and held accountable by consumers. These businesses will provide community level peer support focused on educating the public and providers on the benefits of using formal support to address mental health needs.

The Division has included consumers and families in planning, we will continue that practice and we are open to other ideas on improving that practice.

M. Use of Technology

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care and recovery support services. ICTS are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, e-therapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, videos, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

Using Transformation Transfer Initiatives (TTI) funding, DMHA facilitated a series of trainings that focused on delivering training and information regarding recovery oriented care using Interactive Webinars and e-learning. In addition, during May and June 2011, DMHA leadership utilized videoconferencing to conduct needs assessments to assess recovery oriented care implementation and barriers with sample (10) community providers.

DMHA changed policy/procedures for SOF gate keeping beginning SFY 2012 to allow use of ICTs for alternating contacts to be used for continuity of care meetings with consumers and SOF treatment teams without express written permission from DMHA. However, consumers must be asked and agree to the use of this type of technology.

DMHA contracts with the Indiana Prevention Resource Center (IPRC) for Afternoon Rocks and the Indiana Problem gambling Awareness Program. IPRC has employed the following strategies: Websites, Listserv, Webinar, E-Learning, Skype (monthly), Survey Monkey, Hot Rods Evaluation Program, Geo-coded data for program planning, online college drug and gambling behavior survey.

b. What specific application of ICTs does the State plan to promote over the next two years?

In partnership with OMPP, DMHA will continue to assess and update policy/procedures/rules to support use of ICTs for consumers care and provider support as deemed appropriate.

The IPRC plans to promote: Annual Alcohol, Tobacco, Other Drug, and gambling behaviors survey to be administered online (over 200,000 IN students 6^{th} – 12^{th} grade), and increase webinars and distance learning education to provide more trainings What incentives is the State planning to put in place to encourage their use?

c. What incentives is the State planning to put in place to encourage their use?

In partnership with OMPP, will support reimbursement and rule revisions for services delivered using ICTs as deemed appropriate.

IPRC is planning the following incentives: Webinar and distance learning classes will be free and programs to be required to use online system or complete online evaluations in order to receive reimbursement.

d. What support system does the State plan to provide to encourage their use?

The IPRC is planning the following: Available computer technology specialist for phone consultation, video outline instructions on how to use the technology, utilize free services and easy use programs that people will already have installed on computers (won't require a software purchase)

e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

DMHA will conduct ICTs needs assessment to determine where technology needs exist and develop strategies to address needs. Partnerships among provider as well as seeking out funding for technology development may be some of the options considered for future planning and development.

IPRC barriers to use identified are: restrictions on use, such as state government can't use Skype, varying levels of IT IQ, Out of date hardware (unable to support systems), and satellite internet can't handle/ too slow.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

DMHA leadership is a member of a statewide collaboration involving FQHC/CHC, CMHCs, Managed care organizations, OMPP, DMHA ICCMHC, IPHCA, ISDH, and HRSA. Use of ICTs is one of many issues the group is tackling in its quest to further develop and implement integrated care models across Indiana.

IPRC is adding mental health data to their prevention statistics program that will allow communities to utilize mental health statistics when conducting needs assessments and program planning. Data is already available for a wide range of other information including drug use, gambling behaviors, crime, and protective factors such as schools and religious institutions

g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

IPRC already utilizes technology for evaluation programs. This includes gambling trainings and events, grants, Community That Care (CTC), afternoon ROCKS in Indiana, and the Strategic Prevention Framework (SPF).

h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

IPRC uses survey's after webinars asking about quality of audio/video and if participants would take another webinar or use a distance learning format on this topic again. IPRC also conducts internal cost-effectiveness analysis (paper vs. online).

N. Support of State Partners

The success of a State's MHSBG and SAPTBG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan.

All of the following agencies have accepted invitations to serve on the Mental Health Planning and Advisory Council.

1. The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of initiatives related to behavioral health. Projects and initiatives include but are not limited to the following:
   - Development of a 1915i plan for ongoing habilitative services
   - Submission of a 1915i plan based upon success of the Community Alternatives to Psychiatric Residential Treatment Facilities demonstration project
   - Consultation and collaboration the benefits available to the expanded Medicaid population.
   - Coordination of grant submission to CMS related to housing and homelessness
   - Explore, develop, collaborate on initiatives to support and promote integration of behavioral and physical health including but not limited to health homes models.

2. The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.

   - Coordination of addiction services for offenders re-entry following incarceration
   - Implementation of mental health screening in the juvenile detention centers with subsequent referral for follow up services as indicated
   - Collaboration on the Juvenile Detention Alternatives Initiative (JDAI) under leadership of state judiciary with inclusion of multiple counties, state agencies, and other child serving organizations
   - Regular meetings with advocates, DOC and their MH treatment provider to review treatment services to offenders while in a state facility.

3. The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.

- Targeted educator training for suicide prevention
- Department of Education is working to adopt evidence-based practices and early identification and intervention practice. Some local school systems are using the CANS with youth in special educational-type programs to identify youth with social, behavioral, emotional needs that can be addressed through the school system.

4. The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.
   - The Department of Child Services (DCS) adopted the CANS for use in all residential programs with which it contracts and in all local child welfare offices. The CANS is included as part of its program improvement plan with the federal education agency. The CANS identifies specific needs related to trauma, mental health, and substance use.
   - Coordinated referrals and services between county DCS offices and Community Mental Health Centers.
5. Indiana Bureau of Primary Care which works directly with a variety of primary care and other health organizations including FQHCs, school based health centers, community health centers and rural health programs is the Indiana State Department of Health (ISDH) . ISDH will partner with DMHA and other stakeholders to collaborate in the promotion and facilitation of integrated behavioral and primary health care.

   - ISDH will assist in the development of consistent integration practices across the state.
   - Coordinate linkage and development of partnerships for integration.
   - Provide support and technical assistance in development standards and expectations as well as methods to assess and monitor outcomes of integrated practices.
   - Collaboration with development of the state's suicide prevention plan

O. State Behavioral Health Advisory Council

Indiana Planning and Advisory Council Framework

Indiana has supported six (6) planning or advisory councils for many years.

1. State statute requires a Mental Health and Addiction Advisory Council consisting of eleven (11) members including the Director of DMHA and ten (10) persons appointed by the Secretary of the Family and Social Services Administration who have a recognized knowledge of or interest in the programs administered by DMHA. The Chairs of the following five planning councils were appointees to this advisory council.
2. The Mental Health Planning Council, required by the Mental Health Block Grant, included subcommittees for adults with SMI, children and adolescents with SED, and Special Populations (deaf/hard of hearing, HIV, minority population groups, etc.).
3. The Addiction Treatment Planning Council was formed to provide planning related to the substance abuse treatment part of the SAPT Block Grant.
4. The Addiction Prevention Planning Council was formed to provide planning related to the substance abuse prevention part of the SAPT Block Grant.
5. The Consumer Council was formed to provide an independent voice for consumers in DMHA planning activities. The Consumer Council worked closely with the Mental Health Planning Council, attending the planning council meetings. This Council also met independently of the Mental Health Planning Council and worked separately on some initiatives specific to persons with mental illness and/or addiction.
6. The All Hazards Committee was formed to advise and plan for mental health and addiction participation in state-wide emergency management activities.

The Division of Mental Health and Addiction (DMHA) has taken critical steps in how our Mental Health Planning Council and the Mental Health Advisory Council structures are set up. Our goal is to create one Council that has a charge to move towards a "Good and Modern System." In doing so, the DMHA has taken steps to create a "merged" council that will meet the requirements of the Federal Block Grant along with our State statutes. The proposed name of this merged Council is the "Mental Health and Addiction Planning and Advisory Council." This recreated structure will actively influence decisions on policies and plans related to Adults with Serious Mental Illness, Children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems, while also monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health and addiction services within the State of Indiana.

In order to successfully and appropriately create this merged council, the DMHA sought Technical Assistance from the National Association of Mental Health Planning and Advisory Councils of The Substance Abuse Mental Health Services Administration (SAMHSA). This Technical Assistance facilitated discussion on the following topics: Planning Council Responsibilities; Healthcare Reform and proposed block grant changes; what other states are doing; and strategic planning on merging councils. The strategic planning helped us map out a plan to ensure the merged council is an energized, empowered and proactive group. Our

membership number is projected to not exceed 30 members. Membership selection is based on the requirements of the federal block grant and the state statutes. The by-laws for this merged group will be recreated and reviewed by the appropriate groups to include our legal representative if necessary. New and incoming members will be provided orientation the merged council. Once the membership for this merged council is complete, a kick-off meeting will be held. The kick-off meeting will include discussions such as: How do we want to work; How often should we meet; What's the content of the meetings; Who should we meet with regularly etc. This kick-off meeting will be designed to reorient the new merged council to their new roles and to take the necessary steps to ensure this merged council is an active, energized, empowered, and proactive group.

In order to retain significant capacity for consumers and families to work independently, the Consumer Council will be retained as a separate entity but with representation on the MHAPAC. The All Hazards Committee will also remain independent of the MHAPAC as its responsibilities extend beyond DMHA.

List of Advisory Council Members
Table 11 Plan Year 2012-2013

Name	Agency or Organization Represented
Julia Holloway	State Vocational Rehabilitation Agency
Jolene Bracale	State Education Agency
Sonja Carrico	State Criminal Justice Agency
Rodney Stockment	State Housing Agency
Gina Eckart	State Social Services Agency
Sarah Jagger	State Medicaid Agency
Pat Casanova	State Exchange Agency
James Payne	State Child Serving Agency
Craig Hanks	Department of Correction
Joan M. Duwve, MD, MPH	State Department of Health
Eric Wright, PhD	Indiana University
Rhonda Ames	KEY Consumer
John Browning	Southwestern Healthcare, Inc.
Nancy Cloonan	Family Action Network; Indiana Federation of Families
Stephen Luce	Indiana Sheriff's Association
Stephen McCaffrey	Mental Health America IN
Pam McConey	NAMI, Indiana
Deborah Washburn	NAMI, Indianapolis
John Wilford	
Jeff Catlett	PRTF
Brian Ellis	Mentors of America
Dennis Born	Maximus
Lawrence Erhardt	Community Mental Health Center, Inc.
Jill Matheny	Indiana Addictions Issues Coalition
Sheila Tempel	Harrison County Superior Court
Judge Michael Kramer	Noble Superior Court
Sgt. Angela Andresen	Indiana National Guard
Dr. Yasenka Peterson	Indiana State University
Lisa Hutcheson	Indiana Commission to Reduce Underage Drinking

Behavioral Health Advisory Council Composition by Type of Member

Table 12 Plan Year 2012-2013

Type of Membership	Number	Percent of Total Membership
TOTAL MEMBERSHIP	**29**	
Individuals in Recovery (from mental illness and addictions)	3	
Family Members of Individuals in Recovery	4	
Vacancies (individual & family members)	0	
Others (Not State employees or providers)	8	
TOTAL Individuals in Recovery, Family Members &Others	***15***	***51.72%***
State Employees	10	
Providers	2	
Leading State Experts	2	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
TOTAL State Employees & Providers	***14***	***48.28%***

Comment on the State Plan

Comments on the Mental Health Block Grant (MHBG) and on the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) have primarily involved the advisory and planning councils supported by DMHA. At various times, additional comment was solicited through e-mail distribution lists of stakeholders, including consumers and families. The Division of Mental Health and Addiction Advisory Council, a statutory council, in regular meetings have impacted the planning of the Division and thereby the Block Grant planning. The Mental Health Planning Council and Consumer Council, for the past several years, met regularly every other month. The elements of the block grant application and planning process were part of those meetings. Comment on the current year's plan and input on the next year's plan was solicited. The Indiana Addiction Planning Council, and Prevention and Treatment Subcommittees, in quarterly meetings over the several years, have always included discussions of current activities and future recommendations on the agency in each meeting.

For the 2012 – 2013 application, a more concentrated effort has been made to solicit broader comments. DMHA sent an electronic letter to the planning council and the public that announced they would receive narratives and other information that would be used to complete the block grant application. It was emphasized that DMHA needed their direction and planning to complete the application. As each narrative of a targeted service was completed, it was broadcast electronically to several listservs. As additional sections of the application were completed these too were e-mailed electronically to planning council members, provider organizations with DMHA contracts, and the public for review and comment. One entity also posted the link to the documents on its Facebook page. The DMHA page of the State's website has priority area documents posted with an invitation for public comment. DMHA also contacted providers and had two teleconferences with providers to ensure that they had the opportunity to comment. It is estimated that over 850 individuals and organizations have been invited to review and comment on portions of the plan as it has been drafted.

Comments received thus far from the public, providers, and planning council members have been supportive of the needs assessments and gap analyses documents and the priority areas and strategies identified to address them. There was strong endorsement of the four priority areas and several additional comments regarding enlarging the scope of those four. Several responders commented they had experience in some areas and would be glad to share that with us as we move forward with our plans. There were also a few responders that have volunteered to become more involved in the plans and the work groups that will help to create from those plans. Some responders expressed some concern about the fiscal issues that may come with some of the priority areas. In general, the comments were very encouraging and they will be shared with the planning and advisory council for consideration.

During their first meeting in September, the newly reformatted planning and advisory council will focus on the combined block grant application, the plans developed, the monitoring of the plan steps, and the development of additional goals. Implementation of the State Plan for mental health and addiction will be an on-going topic for the planning and advisory council.

The completed combined State plan will be made available on the State's website for continuous opportunity to review and comment. As updates to the State plan occur over the next two years, these will also be posted to the website for public comment.